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I. 63 No. 1

Medical Journal

JANUARY 1967

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eferences: (1) Siver, R. H.: CMD, *21*:109, September 954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, anuary 1955. (3) McGivney, J.: Tex. State Jour. Med., *1*:16-18, January 1955. (4) Quehl, T. M.: Jour. of lorida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Veekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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NOV 12 1968

JANUARY
1967

Vol. 63 No. 1

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Assaciatian

Box 1031 Charleston, W. Va. 25324

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Originol articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50c per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

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The West Virginia Medical Journal

Vol. 63, No. 1 January, 1967

Radiation Pneumonitis as a Complication of Postoperative Treatment of Carcinoma of the Breast: Clinical And Radiographic Studies

W. M. Burns, M. D., W. J. Howland, M. D., J. L. Curry, M. D, and A. K. Butler, M. D.

It has been known since 1922[1] that irradiation can produce inflammatory reaction in lung tissue. The literature on the subject is voluminous. Nevertheless, difficulty persists in evaluation of this entity. Interpretation of the radiographic abnormality and decision regarding possible treatment are difficult. Among other things, an apical infiltrate due to radiation pneumonitis can produce appearances similar to metastases or pulmonary tuberculosis.

Several years ago, we were prompted to undertake a systematic study in order to determine the incidence and significance of radiation pneumonitis following a standard program of radiation therapy after radical mastectomy for carcinoma of the breast. Our study is based on a series of 100 cases in which the patients were subjected to a standardized postoperative radiation program.

Materials and Methods

All patients referred to the radiation department of Ohio Valley General Hospital for postoperative radiation therapy following radical mastectomy for carcinoma of the breast receive a standard treatment series (Figure 1).

Field 1 encompasses nodal drainage areas to ipsilateral supraclavicular, axillary and lower cervical regions and receives a total air dose of 4,500 r given with Co^{60} Teletherapy at a 60 cm. distance. This is delivered at the rate of 200 r per day.

Field 2 encompasses internal mammary nodal drainage areas and receives a total air dose of 4,000 r given with Co^{60} Teletherapy at 40 cm. distance at the rate of 200 r per day.

Submitted to the Publication Committee, June 15, 1966.

The Authors

- W. M. Burns, M. D., W. J. Howland, M. D., J. L. Curry, M. D., and A. K. Butler, M. D., Department of Radiology, Ohio Valley General Hospital, Wheeling, W. Va.

FIGURE 1.

Figure 1. Radiation therapy fields for breast carcinoma. Field 1. Axillary-supraclavicular 10 x 20 cm.; Field 2. Internal mammary 7 x 15 cm.; Field 3. Anterior chest wall—lower costal margin to above fields.

Field 3 encompasses the ipsilateral anterior chest wall and receives a total air dose in the range of 1,750 r to 2,500 r depending on skin tolerance, given at the rate of 150 r per day with 140 KV irradiation, 4 mm. of aluminum added filtration at a distance of 35 cm. Treatment to all fields is given five days per week. The average course of therapy is approximately four and one-half weeks. These doses are calculated to give a tissue dose of 3,500 r at a depth of 5 cm. for Field 1, a depth of 3 cm. for Field 2, and at the skin surface for Field 3.

All patients were reevaluated three months following the completion of therapy. At this time, a chest x-ray was obtained and all patients were closely questioned in regard to pulmonary symptomatology. If the chest x-ray suggested radiation pneumonitis, the patient was asked to return at monthly intervals until a stable roentgen appearance of the chest was obtained. Since only occasional pulmonary function studies were obtained, they add no significant information.

All available chest x-rays of these 100 consecutive patients in whom progress x-rays were available for review were interpreted independently by the four authors without prejudicial knowledge of the interpretation by the other three. The radiograph obtained three months after completion of therapy was considered film No. 2 in all series of films, and a pre-radiation film was available for comparison in all but 24 cases. Subsequent films at monthly intervals were evaluated for progression or regression of the abnormal findings, and followed to a stable appearance.

The radiation reaction was graded zero to four as follows:

Grade O—Negative. No change attributable to pulmonary radiation. At least three of the readers graded each film as normal or no change from prior films.

Grade I—Subminimal. Minimal linear fibrosis. No consolidation. At least two readers read these films as Grade I with no more than one reader grading either film higher.

Grade II—Minimal. Small, circumscribed consolidation or moderate linear infiltrates. At least two readers read these films as Grade II with no more than one reader grading either film higher.

Grade III—Moderate. Greater consolidation with or without linear infiltrates. At least two readers read these films as Grade III with no more than one reader grading either film higher.

Grade IV—Severe. Extensive consolidation with or without linear infiltrates. At least two readers graded each film as Grade IV. Figure 2 illustrates Grade IV radiation pneumonitis.

None of the 100 patients was given any treatment for radiation pneumonitis. A few had received therapy for a "cold" by their referring physicians before our three-month examination.

Results

Table 1 summarizes the incidence of radiation pneumonitis seen in our series of cases. Thirty-eight patients were considered by one or more of the radiologists to have no visible evidence of pulmonary radiation reaction. Sixty-two had definite radiographic abnormalities as seen on the three-month film. Only eight of the 62 complained of any significant respiratory symptom. Their complaint was of a mild to moderate cough. One of the 38 patients with no significant radiographic evidence of radiation pneumonitis also complained of cough (Table 1).

Table 1

Incidence of Radiation Pneumonitis and Cough

Grade	*No Symptoms*	*Mild Cough*	*Much Cough*
0	37	1	0
I.	27	1	1
II.	15	2	0
III.	10	1	1
IV.	2	2	0
Totals	91	7	2

Table 2 summarizes findings in the 16 cases with moderate to severe radiation reaction of the pulmonary parenchyma. All of these patients showed lessening in severity of the x-ray abnormality over a period of several months, with a stable appearance usually reached within seven months after completion of therapy. In only one of these cases did the reaction increase over the three-month period. A single patient (No. 4) had severe cough. This patient received no specific therapy and the cough gradually disappeared. The chest x-ray showed gradual improvement over a period of four months.

Those patients with Grade III to Grade IV changes were carefully studied in an effort to ascertain what observations, if any, distinguished them from the rest. The average age of patients showing the advanced x-ray abnormalities was 60 years. The average age of those in the entire series of 100 cases was 57 years. Many other factors were considered with regard to potential influence upon the development of radiation pneumonitis but no positive correlation was identified. These factors included size of patient, extent of surgery, time after surgery when radiation was begun, complexion of patient, skin reaction observed, and presence of diabetes or other illness.

No late disability or radiation sequelae developed in any of these patients. In two cases, pleural effusion developed several years after radiation treatment but in both instances it was proved to be due to pleural metastases.

Discussion

Smith[2] has written a comprehensive article dealing with radiation pneumonitis in which he has summarized many aspects of radiation pneumonitis, including historical background, incidence, clinical features, pathology, physiology, prognosis and treatment. In addition, he ponders the etiology of radiation pneumonitis, as have other authors for over 40 years. Noteworthy in his article is the disagreement among investigators on most aspects of this disease. In his final comments, he states, "Although knowledge has been advanced by these endeavors, two important points remain obscured: why some patients develop radiation pneumonitis while others do not, and why in some patients the disease process subsides spontaneously, while in others the condition progresses relentlessly. The answers to these questions have not been found."

Complications from radiation over the lung fields include progressive pumonary fibrosis, pulmonary atelectasis, chronic pneumonia, bronchiectasis, pleural thickening, fibrothorax, indurated, contracted intercostal muscles, mediastinal shift, diaphragmatic elevation, scoliosis toward the affected side, pleural effusion, fever, lassitude, chronic cough, dyspnea, orthopnea, cyanosis, chronic right heart failure and death.

Results of our investigation present no data at variance with prior reports. It is interesting to us, however, that we encountered no severely progressive disease, whereas several authors with smaller series have reported a number of deaths from what they interpreted as radiation pneumonitis and fibrosis.

Table 2

Grade III and IV Radiation Pneumonitis

Pt. - No.	*3 Mos. Post Rx. Reaction*	*Last Appearance*	*Symptoms*
Z. A.- 2	III.	II.	None
E. C.- 4	IV.	I.	None
M. C.- 5	IV.	II.	Slight cough
M. H.-16	III.	II.	None
M. H.36	III.	Unknown	None
E. M.-38	III.	I.	None
L. S.-39	III.	I.	None
D. L.-43	III.	I.	Severe cough
B. M.-46	III.	I.	Mild dry cough
M. S.-55	III.	II.	None
G. J.-65	IV.	II.	Slight cold with mild cough for few days
G. K.-68	III.	I.	None
B. R.-70	III.	II.	None
L. B.-72	III.	I.	None
A. S.-85	III.	II.	None
H. Z.-88	III.	II.	None
M. S.-96	II. (IV at 6 mos.)	II.	None

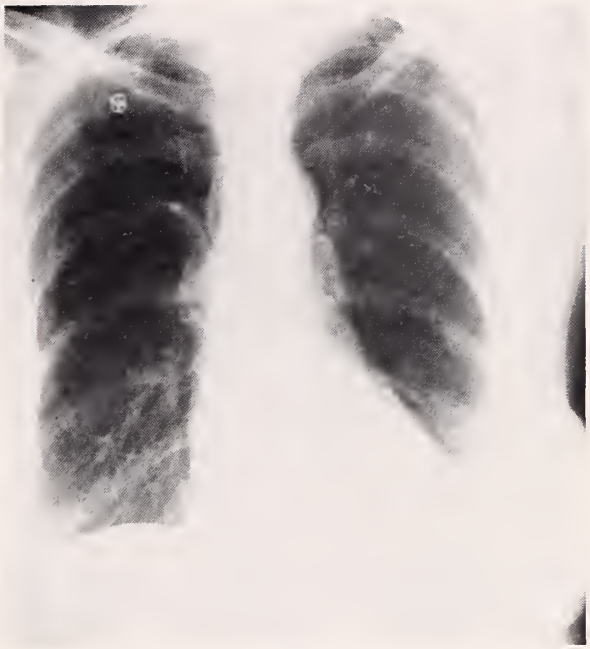

FIGURE 2-A

Typical Grade IV radiation pneumonitis. Pretreatment film of 5-11-64.

Why moderately severe to severe radiographic changes should develop in some of our cases, to be followed by spontaneous improvement and no late sequelae nor disability is a further interesting point. Many of the reported cases of severe radiation pneumonitis occurred before the advent of antibiotics and corticosteroids, which may account for the lack of progression of severity of radiation pneumonitis and fibrosis in certain recent cases. In our particular series, this would not appear to be a contributing factor as none of our patients was severely symptomatic. None of our patients is expected to progress to chronic right heart failure as a result of gross pulmonary change; these cases, however, have not been followed sufficiently long for us to be certain of this. To date, in our series of cases, we know of no occasion of bronchiectasis having occurred from radiation treatment over the lung fields.

The following considerations may account in part for our relative lack of severe complications:

1. A second course of radiation therapy was given to none of our treatment fields.
2. The total dosage to the underlying pulmonary parenchyma was at a relatively low level.

3. Although the size of our portals was generous, only the apical portions of one lung and a limited area of retrosternal pulmonary parenchyma was included in the treatment field.

FIGURE 2-B

Typical Grade IV radiation pneumonitis. Three months post radiation therapy film of 9-18-64.

FIGURE 2-C

Typical Grade IV radiation pneumonitis. Progress film of 7-26-65.

4. The intensity of the radiation to the pulmonary parenchyma was well under 1,000 r per week.
5. There was no known serious disease of the pulmonary parenchyma in any of these cases prior to treatment.
6. No known metastatic disease either of the pulmonary parenchyma or mediastinum was present prior to or during treatment.

Our study indicates that we are not encountering the severity of clinical disease described in some literature reports. The relatively low incidence of clinical disease with radiographic evidence of radiation pneumonitis is noteworthy. If we had obtained films during the course of treatment, at the termination of treatment, and at an early period following the completion of treatment, we may have encountered some additional cases of minimal radiation pneumonitis which resolved rapidly.

One interesting consideration to the questions posed by Smith[2] is presented in a report by Kojima,[3] et al. From their histologic findings, they have suggested that the two types of radiation pneumonitis resemble an allergic reaction. In their cases, they find that the alveolar exudative type of radiation pneumonitis resembles the histologic findings of rheumatic pneumonia, and the features of interstitial radiation pneumonitis resemble changes seen in the lungs of patients with rheumatic endocarditis. Specifically, they claim that the formation of Masson bodies and the cordlike protrusions into the walls of the alveolar ducts and bronchioles never occur in nonallergic conditions but that each of these is found in radiation pneumonitis. In their experience, these allergic changes in radiation pneumonitis were never seen until after absorption of necrotic debris from desquamated alveolar and bronchial cells; therefore, they conclude that the necrotized tissue acts as an antigen. They cite Tarusawa[4] and Sasamoto[5] who have demonstrated that radioactive-iodine-labeled antibody from necrotic alveolar cells will initiate an antigen-antibody reaction. To our knowledge, these interesting findings have not been confirmed by investigators in the United States. Inclusion of the allergist in research teams perhaps would shed further light on the problem of radiation pneumonitis.

Summary

1. Of 100 post-mastectomy radiation therapy patients given a standard course of Cobalt and superficial treatment, 62 showed radiographic evidence of radiation pneumonitis.

2. Only eight of the 62 had cough. One patient without radiation pneumonitis had cough. No other pulmonary symptom was encountered.
3. All patients with radiation pneumonitis showed resolution of the greater portion of the pneumonitis, many to a near normal appearing chest.

Acknowledgment

The authors acknowledge with sincere appreciation the great amount of assistance given by Miss Margaret Hadorn in the clinical research for this paper.

References

1. Tyler, A. F. & Blackman, J. R.: Effect of Heavy Radiation on the Pleurae and Lungs, J. Radiol. 3:469, 1922.
2. Smith, J. C.: Radiation Pneumonitis: A Review, Am. Rev. Resp. Dis. 87:647-655, 1963.
3. Kojima, K., Kitamura, S., Watanabe, K. & Matsukawa; A.: Histological Studies of Radiation Pneumonitis, Acta Path. Japonica 9:951-968, 1959.
4. Tarusama, S.: A Serological Study of Ionizing Radiation to the Body, Nipp. Acta Radiol. 17:466-497, 1957.
5. Sasamoto, N.: Experimental and Clinical Studies on Autoantibody Generated by X-Ray Irradiation on the Lung, Nipp. Acta Radiol. 18:955-988, 1958.

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References: 1. Pillsbury, D. M., Shelley, W. B., and Kligman, A. M.: A manual of cutaneous medicine, Philadelphia, Saunders, 1961, p. 79. 2. Barber, M., and Garrod, L. P.: Antibiotic and chemotherapy, Baltimore, Williams and Wilkins, 1963, p. 111.

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A Unique Learning Experience: Community Health in a Rural Area

Joseph J. Schwerha, M.P.H., M. D., Ernest W. Chick, M. D., and Marilyn A. Jarvis, M. D.

WITHOUT showing actual examples, it is difficult if not impossible to instill in the minds of medical, dental and nursing students appreciation of community health problems. To present both problems and methods of community health care only by lecture is comparable to teaching medicine and surgery in the lecture room without bedside experience, as decried long ago by Osler.

To explore the possibilities of "bedside teaching" in community health, a survey of a rural, nonfarming, nonmining, nonindustrial community in South Central West Virginia was made (Figure 1). The community consisted of 239 persons living in 69 homes. The purpose of the study was threefold:

(1) To develop a field learning experience in community health for medical, dental, nursing and medical technology students.

(2) To develop a method for collecting and analyzing data.

(3) To define the health status of the community in question.

Methodology

The study was developed in two parts: the household medical questionnaire and the physical examination. The household questionnaire was designed to provide information concerning the past health of each individual in the household and additional socio-economic information which would be helpful in evaluating his health status. The health questionnaire was developed by the authors, patterned after the Cornell Family Illness Study and a questionnaire by Jarvis et al.[1] The questionnaire was handled by a senior medical student who spent six days in the community in a door-to-door survey. The information was coded instantly to eliminate additional manipulation before being processed by computers. During the interview, mention was made of the physical examination and its value was emphasized.

Approximately two weeks after the interview a team of professional persons of the types listed below visited the area with the purpose of examining each individual.

Submitted to the Publication Committee, June 11, 1966.

The Authors

Joseph J. Schwerha, M.P.H., M. D., Ernest W. Chick, M. D., and Marilyn A. Jarvis, M. D., Division of Preventive Medicine, West Virginia University School of Medicine, Morgantown.

Team members were selected from the following list:

2 Staff physicians
(School of Medicine Faculty)
2 Senior medical students
1 Dentist
(School of Dentistry Faculty)
1 Senior dental student
1 Dental hygiene student
1 Nurse
(School of Nursing Faculty)
3 Nursing students
2 Medical technology students
1 Microbiology graduate student

This team worked in the community for one week, performing the physical, dental, or laboratory examinations as well as developing a better understanding of environmental factors as they affect health. The time chosen for the field examinations was the semester break when the personnel have free time from other academic responsibilities.

The comprehensive physical and dental examination with supporting laboratory procedures included hematocrit, WBC, differential blood count, urinalysis, and stool examination for ova and parasites. Electrocardiograms were done on all persons over 40 years of age and on those with heart abnormalities. The Papanicolau smear for cervical cancer was made on married females.

The data were correlated and tabulated on return to the Medical Center. Approximately two weeks after the field examinations a member of the medical team returned to the community and visited each home, giving the nondiagnostic, "lay" interpretation of the findings in the case

Community B

Figure 1

of each individual. Encouragement was given each to seek treatment from his physician, as indicated. A detailed copy of the findings was sent to the physician of the individual's choice. No definitive diagnosis was made and no treatment of any kind was given during the survey. Persons with acute conditions, when found, were referred immediately to the private physician for treatment.

Results

Ninety-five per cent of the families were willing to answer the health questionnaire (Table 1). Two-thirds of the families had lived in the community more than 20 years (Table 2) and approximately one-third of the adults had a sixth grade education or less (Table 3). The income varied (Table 4) with half of the families having an income of $3,000 or less and two families with incomes greater than $10,000 per year. In some cases the appearance of the home was not a reflection of the amount of income.

Sixty-two per cent of the families used an outside toilet (Table 5). Thirty-four per cent of the people used a dug well for their supply of drinking water. Fourteen families used their neighbor's source of drinking water. At least five households carried drinking water from one neighbor's drilled well.

Use of available medical care is reflected by deliveries (Table 6) over the last two decades. Over half the deliveries in the 1946-1955 time period were done in a doctor's office as compared with a small percentage in the following 10-year period. In both decades most of the deliveries were attended by a physician.

The number of persons immunized and the current status of these immunizations (Tables 7 and 8) show high participation by the community. The 0-6 age group is of particular interest in the high number of youngsters with D.P.T. immunizations and smallpox vaccinations. This, in part, is due to the fact that the county health department held clinics in the community school house within walking distance of every home. A "Sabin Sunday" also was held in this community, a fact which probably explains the high rate of Sabin immunizations. Some young people are now starting to get the measles vaccine.

The over-all community participation in the physical examinations was 62 per cent. This acceptance rate may be compared with that of the National Health Survey physical examinations which is approximately 60 per cent.[2] The higher per cent participation by females and young children in the community is due, in part, to greater availability of the females during the day and to the fact that the school children were excused from school for these examinations.

Comparison of findings from the medical history with those on physical examination (Table 9) demonstrates the number of unknown abnormalities found. Twenty-four persons were found to be anemic, with no previous history of anemia. Thirty-five were found to have a heart abnormality, with no previous history. Seven instances of thyroid abnormality were found, with a previous history in one. Visual acuity was less than 20/30 in one or both eyes of 22 individuals. Of 38 Papanicolau smears made, one was Class IV. The dental examination revealed a D.M.F. rate (decayed, missing, filled teeth) of 20.0 per person, with extremely poor personal oral hygiene.

Comment

The students had many unique learning experiences. They were able to see how academic material learned in the classroom actually applied to the general health of a community and to the different problems that may arise in practice.

The merit of regular examinations was again brought to the foreground by the number of abnormalities found on physical examination that

were not elicited by medical questionings. In many instances these were treatable illnesses and prompt treatment could prevent more serious complications.

The effect of adequate immunization also was evaluated with respect to whether an individual had the clinical disease. Whooping cough was reported by history in more persons over the age of 30, emphasizing that immunization, when accepted, does decrease the incidence of disease.

Another important facet was the experience of working with persons in their own area instead of caring for them in a hospital. When a patient is in the hospital, he is in a strange environment over which other people have control. In his home area he has more freedom to choose for himself whether or not he participates. This option challenges the student to stimulate the patient's interest in health.

The students saw the actual living conditions of the people and had an opportunity to think how prevention and treatment might be adopted for effectiveness in a rural area. Their consensus was that basic hygiene and sanitation should be taught to the people on a community basis, a program which would take little professional time and which could improve general health and decrease infection. The value of early treatment of severe sore throat could prevent complications such as rheumatic fever. Proper oral hygiene would prevent dental caries and provide better nutrition through the greater ability to masticate. Diagnostic clinics could detect the early stages of chronic disease if the people were motivated to use them. If the population does not understand the value of good hygiene and early detection and treatment of illness, the best medical knowledge is of no value.

Summary

A method for collecting and analyzing demographic and medical data is presented. The data collected demonstrate some of the medical problems that exist in a rural West Virginia "hollow." The picture holds true only for the particular community and cannot be extrapolated to the entire state.

From a learning standpoint, the participating students had an opportunity to evalute community health, to discuss the problems in relation to environment, and to discuss methods for providing better care in rural areas.

Acknowledgment

This study would not have been possible without the interest and cooperation of the following:

West Virginia State Department of Health.

County Health Departments.

Cooperative Extension Service of the Appalachian Center.

Participating Students and Faculty of the Medical Center.

Numerous Community Volunteers.

References

1. Jarvis, M. A., Chick, E. W., Six, R. & Wheatley, E.: Health in a Semi-Isolated West Virginia Community. Arch. Environ. Hlth., 13:422-428, Oct. 1966.
2. United States National Health Survey Series No. 4 A, Washington, D. C., U. S. Dept. H.E.W., P.H.S. 1962.

Table 1

Population Distribution by Age, Sex, and Participation in Health Survey: Community B, West Virginia, 1966

		Male		*Female*	
Age in Years	*Total in Age Group*	*Interview Only*	*Interview and Physical*	*Interview Only*	*Interview and Physical*
0 - 6	34	4	17 (81%)	0	13 (100%)
7 - 12	33	3	15 (83%)	1	14 (93%)
13 - 18	34	9	9 (50%)	7	9 (56%)
19 - 30	30	9	3 (25%)	6	12 (67%)
31 - 45	42	13	8 (38%)	4	17 (81%)
46 - 65	41	11	7 (39%)	11	12 (52%)
> 65	5	5	5 (50%)	7	3 (30%)

Table 2

Number of Years Each Family Has Lived in Community B, West Virginia, 1966

Years in Community	*Number of Families*
< 2	1
3 - 5	2
6 - 10	9
11 - 15	8
16 - 20	3
> 20	44

Table 3

Education Level of Adults Community B, West Virginia, 1966

School Grades Completed	*Number of Heads of Households*
None	0
< 3 Grades	4
4 - 6	20
7 - 9	24
10 - 12	12
> 12	7

Table 4

Annual Income by Family
Community B, West Virginia, 1966

Annual Income	*Number of Families*
$ < 999	10
1,000 - 1,999	17
2,000 - 2,999	6
3,000 - 4,999	16
5,000 - 6,999	10
7,000 - 9,999	6
> 10,000	2
	—
	67

Table 5

Sanitary Facilities,
Community B, West Virginia, 1966

Toilet Facilities	Septic Tanks	23
	Dug Pit	36
	Privy	5
	Other	3
		—
		67
Drinking Water	Drilled Well	29
	Dug Well	23
	Spring	1
	Neighbor	14
		—
		67

Table 6

Care as Reflected by Deliveries
Community B, West Virginia, 1966

	1946-1955	*1956-1965*
Live Babies Delivered at:		
Hospital	18	30
Doctor's Office	21	8
Home	2	0
Live Babies Delivered by:		
Physician	39	38
Nurse	0	0
Midwife	1	0
Other	1	0

Table 7

Immunization Level, Children and Adults
Community B, West Virginia, 1966

Age Group	*Total Number*	*History of D.P.T.*	*D.P.T. <5 Yrs. ago*	*History of Smallpox*	*Smallpox <5 Yrs. ago*
0 - 6	34	25	24	25	24
7 - 12	33	33	32	33	32
13 - 18	34	32	31	32	31
19 - 30	30	28	0	29	0

Table 8

Immunization Level, Children and Young Adults
Community B, West Virginia, 1966

Age Group	*Total Number*	*Salk Vaccine <5 Yrs.**	*Sabin <5 Yrs.**	*Measles Vaccine*
0 - 6	34	11	22	6
7 - 12	33	19	20	6
13 - 18	34	17	22	5
19 - 30	30	—	5	1

*Some overlap; Columns may not be added.

Table 9

Correlation of Medical History with Physical Examination Findings*
Community B, West Virginia, 1966

Question asked by Interviewer	*Affirmative, but not Substantiated by Examination*	*Affirmative, and Substantiated by Examination*	*Negative, but Found on Examination*
Anemia	13	2	24
Heart Disease**	2	6	35
Blood Pressure >140/90	6	10	12
Thyroid Disease	2	1	6
Chronic Skin Trouble	3	2	10
Trouble Seeing	5***	4	22
Positive TB Skin Test	0	0	25

*144 People examined
**Murmurs & abnormal E.K.G.
***One not tested, mentally retarded

Now, now, Mrs. Forsythe, we've never lost a cold patient yet.

When she's experiencing acute discomfort from cold symptoms, it's small wonder the patient becomes distressed about her condition.

She will breathe easier when you prescribe Novahistine LP.

Novahistine LP is a long-acting decongestant that helps restore normal mucus secretion and ciliary activity—physiologic mechanisms which prevent infection of the respiratory tract. A dose of two tablets taken in the morning and repeated in the evening will usually keep air passages clear for 24 hours.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution patients who operate machinery or motor vehicles that drowsiness may result.

Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

DOW PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis

NOVAHISTINE® LP

For relief of nasal congestion.

Special Article

Psychological and Medical Aspects of Alcoholism*

Carl B. Hall, M. D.

In spite of the recently acquired status of alcoholism as a medically recognized disease, its cause remains unknown and its course and prognosis are uncomfortably variable. It is generally assumed, however, that there is such a thing as an alcoholism syndrome, a cluster of traits, conditions or behaviors which are widely, though perhaps imperfectly, shared by the bulk of alcoholics.

Alcoholism has been defined in many ways, but from the viewpoint of the practicing physician, the following may be most helpful:

"Alcoholism," according to Keller and Efron, "is a chronic illness, psychic or somatic or psychomatic, which manifests itself as a disorder of behavior. It is characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary dietary use or compliance with the social customs of the community and that interferes with the drinker's health or his social or economic functioning.

"Many special categories of alcoholics have been identified, including alcoholic addicts, who cannot control their drinking, and alcoholics with complications. The latter are those whose excessive drinking has led to recognizable physical or mental sequels."

This definition is in general agreement with the idea held by most observers in this country who also agree that there are two components of the disease: psychological and physiological.

There seems to be ample evidence that alcoholism is due to the effect of alcoholism on the body, or to the reaction of the body to the ingestion of alcohol. The reasoning behind this is roughly as follows:

1. There would be no alcoholism if the patient did not take alcohol into his system.

2. There is no evidence of a cure in the sense that a patient once proved to be alcoholic can return to social or "normal" drinking again.

*Presented before West Virginia's Second Annual School of Alcohol Studies, June 14, 1966.

Submitted to the Publication Committee, July 1, 1966.

The Author

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3. The alcoholic presents evidence of a true physiological addiction.

4. There is some evidence of difference between the metabolism of alcohol in the alcoholic and of that in the nonalcoholic.

On the other hand, it cannot be denied that the alcoholic patient has many and varied psychological problems. Workers in the field disagree on how many and how varied. They disagree also on the extent to which these problems are caused by basic personality and neurotic patterns and that to which they are the results of alcoholism.

Psychiatrists believe that dependence upon alcohol will be seen to operate in dealing with anxiety, guilt, aggression, inadequacy, depression, sexual urge, perversion, physical pain, psychoses, neuroses and character disorders. A great variety of psychopathological reactions are interwoven with the addiction process.

It would appear that the symptom of alcohol dependence always represents a mode of adaptation, perhaps the sole adjustive mechanism to living problems that is available at the moment. It is a symptom representation, a behavioristic reflection of some form of psychological stress-functioning, an attempt to meet, deal with or master some form of intrapsychic imbalance, conflict or excitation. It is a kind of last-grasping toward something so as to forestall the horror of inevitable disintegration, of psychic disorganization that spells doom and total helplessness. The addicted person has found something that he knows will give him relief from unbearable tension and anxiety. Even a strong wish to be rid of the drug substance is complicated by an even stronger fear of his real ability to function without it. To suddenly deprive him of this

mechanism without replacing it with something at least almost as effective is inflicting harm in the name of help.

Once introduced to the alcohol, however, such a person will never forget its effects. The initial use of alcohol produces an incomparable sense of well-being, self sufficiency and security. Problems no longer exist; decisions do not have to be made. Alcohol is the decision. The memory of this experience beckons as a panacea for all the unbearable frustration of daily living. Once the alluring invitation is accepted, addiction is almost inevitable.

Be that as it may, the many phases of alcoholism so often presented, I believe, give us a more practical understanding of the behavior problems and the alcoholic's reaction to the use of alcohol in the development of the many serious problems inherent in the condition we know as alcoholism.

Phases of Alcoholism

Phase I. *Pre-Alcoholic stage.* The first steps toward alcoholism begin when drinking gets beyond the social stage; alcohol begins to take a definite part in the living pattern and needs of the drinker; it begins to mean more to the drinker than to other people; he finds psychological relief in drinking and begins to seek out that relief. The symptoms are:

Flagrant Drinking Behavior. He drinks more, and he drinks more often.

Blackouts. A kind of amnesia occurs in which the drinker has gaps in memory.

Gulping And Sneaking Drink. He slips extra drinks and carries a private supply.

Psychological Hangover. He has feelings of remorse and guilt. In the pre-alcoholic state, the person has not yet lost control of his drinking to the extent that it is compulsive.

Phase II. *Early stages of alcoholism*—The tempo of drinking increases; the ability to stop is leaving him. The symptoms are:

Loss of Control. This is the mark of an alcoholic. In this early stage he can refuse to start drinking, but after he once starts he cannot stop. A single drink acts as a trigger that leads to complete intoxication.

Alibi System. He attempts to justify his drinking to his family, friends, employer and himself.

Eye-Openers. There is need for a morning drink to kill painful hangover and feelings of guilt and remorse.

Changing The Pattern. Because of pressure from family or employer, he tries to break the hold that alcohol has on him by changing the type of beverage. He makes rules about his drinking—when and how much—and goes "on the wagon" for various periods.

Antisocial Behavior. He broods over imagined wrongs. He begins drinking alone or with other alcoholics regardless of social level. He becomes highly critical of others (self-defense) and may become destructive or violent. He thinks people are staring at or talking about him (guilt).

Loss Of Jobs And Friends. Antisocial behavior leads to loss of jobs and friends. He may "jump the gun" and quit his job before he gets fired or may drop his friends first.

Seeks Medical Aid. He goes to doctors and hospitals but seldom is helped because at this stage he refuses to cooperate.

Phase III. *Later stages of alcoholism.* The alcoholic drinks to live. He gave up his problems to alcohol; now alcohol demands the surrender of his personality. In the early stages of alcoholism the victim could choose to drink or not to drink. There is no choice left now; he must drink however and whenever he can.

Characteristics of this phase of alocholism are:

Benders. He drinks around the clock, becoming blindly and helplessly drunk. He disregards everything—family, friend, job, even food and shelter. He drinks to escape problems created by drinking. He drinks against his will.

Tremors. He gets the "shakes," a serious nervous condition. Alcoholic sickness, brought on by prolonged malnutrition, can begin at this stage. In some cases, the alcoholic has delirium tremens, a mental disorder characterized by extreme nervousness and hallucinations. He may refrain from drinking for various periods, but goes back to the bottle sooner or later.

Protecting The Supply. He will do or sell anything to buy liquor. He will hide it or do anything else to protect it. Solitary drinking often is brought on by fear of running out of alcohol. Having a supply has become the most important thing in his life.

Unreasonable Resentments. He shows hostility toward others, both as a protection to his supply and as a manifestation of an unconscious desire to punish himself.

Nameless Fears And Anxieties. He fears things that he cannot definitely pin down or put into words. He acquires a sense of impending doom or destruction. Nervous and shaky, he is unable to face life without alcohol.

Phase IV. *Beginning of the turn.* This is the end of the journey.

Collapse Of The Alibi System. No longer can he make excuses or put the blame on others. He realizes that drinking is beyond his control and admits that he is defeated (this may happen during earlier stages and be repeated many times.)

Surrender Process. He must give up the idea of ever taking another drink of alcohol in any form. This follows collapse of the alibi system and must come with an end to self deception if he is to recover. He must admit to himself that he is an alcoholic and, even more important, must accept his alcoholism as an incurable condition. He must seek and accept help.

The symptoms of alcoholism do not necessarily follow the precise order as herein outlined. Regardless of order of occurrence, the symptoms that alcoholics experience are distinct and visible. Each of these symptoms may not appear in each alcoholic. Individual alcoholics differ, but these stages will be recognized by any problem drinker.

Physiological Symptoms

The vast majority of alcoholics have physiological symptoms as a result of their alcoholism and many must be under medical care for them. But because the alcoholic usually wishes to keep his addiction hidden, and "because of the popular misconception of the typical alcoholic," physicians are failing in many cases to recognize alcoholism as the underlying cause of physical symptoms. Hence, it would seem helpful to review symptoms that characteristically arise as a result of excessive drinking.

The facial appearance is the first area affected overtly. The capillaries around the conjunctiva of the eye become engorged, and a puffy, edematous appearance is noted in the skin and subcutaneaus tissue of the face and forehead. In fair-skinned persons, flushing of the skin is common, with pronounced hyperemia which, after a long period develops into "whiskey nose." Edema also may be observed in the nasal mucous mumbrane and the posterior pharynx, extending into the larynx and vocal cords, the latter causing the alcoholic's characteristic horseness. It also is to be noted that the gag reflex of the alcoholic is greatly exaggerated.

Perhaps the most common form of pathologic change in the stomach is alcoholic gastritis, which is manifested by loss of appetite, frequent periods of nausea, and occasional vomiting after a drinking episode. Blood in the vomitus often is found, and evidence of irritation of the lower intestinal tract, such as diarrhea, may be noted.

Alcoholic tremor is one of the most common of the physical changes associated with excessive drinking, and the tremor may persist long after the patient has ceased to drink. The tremor is aggravated when the patient attempts to stop drinking, reaching its peak intensity immediately upon complete withdrawal of alcohol.

The exact causes of the specific cerebral metabolic disturbances produced by alcohol withdrawal are not yet known. The manifestations are those suggesting hyperactivity of the various cerebral structures, either in the form of abnormal functional stimulation or as a release phenomenon caused by exhaustion of a governing mechanism. In any case, there usually is little doubt about the diagnosis when the physician sees the alcoholic at the termination of a prolonged bout of drinking. Along with acute tremulousness, or the "shakes," caused by motor hyperactivity, the patient suffers from severe anxiety, a markedly reduced startle threshold, insomnia and disturbing feelings of unreality and inability to concentrate.

There is evidence of marked dehydration as the result of the diurectic action of alcohol, and of starvation as the result of reduced food intake, nausea, vomiting and diarrhea.

In approximately 25 per cent of tremulous patients, hallucinations may develop within 24 hours after alcohol withdrawal, although the patients often are able to communicate coherently and even to describe their hallucinatory experiences.

Delirium tremens appears to be a combination of tremulousness and hallucinosis in their severest forms. Grand mal seizures (convulsions) or "rum fits" may initiate this syndrome, which usually occurs after the first and before the fifth day of abstinence. Tremor is coarse and severe and the patient cannot be diverted to reality. He constantly mutters or speaks incoherently and is disoriented as to time, place and person. Hallucinations are vivid and often assume the form of the bizarre, usually large and fast moving animals or animal-human combinations. Auditory delusions or hallucinations are less common and usually are in the form of threatening human voices. Associated autonomic disturbance is manifested by hypertension, mydriasis (dilated pupils), tachycardia and profuse diaphoresis (sweating). There also may be temperature elevation despite the absence of infection.

Total Care of the Alcoholic

Despite differences of opinion among experts, there is unanimous agreement that alcoholism can be treated effectively. In the United States

the many thousands of alcoholics who have stopped drinking constitute convincing evidence that this is so. Although alcoholism never can be cured, it definitely can be arrested as effectively as tuberculosis or diabetes.

I view the total care or treatment of the alcoholic in three different areas:

1. Prevention.
2. Acute Intoxication.
3. Rehabilitative or Follow-Up.

1. *Prevention.* It is in this area that I believe most can be done by education. Education of the individual to the dangers of alcohol and resulting alcoholism should be an integral part of our educational program just as are reading, writing and arithmetic, and should be started at least at the Junior High level and continued through high school, college and adulthood, that is to say, to every adult who will stand and listen. I believe that the present approach by way of guest speakers to small groups, by pamphlets, films or other forms of simple approach does not reach deep enough into the everyday life of the individual. More must be done in our educational system. None of us is so naive as to think there ever will be an end to the drinking of alcoholic beverages (what with the economic and social pressure), but we can work toward letting the individual make up his mind whether or not to drink, after he has been told of the many dangers of drinking.

Dr. William B. Terhune, Medical Director of The Silver Hill Foundation, in a paper presented before the 39th Pan American Association Congress, stated that physicians should instruct their patients to observe the following ten rules to avoid the development of alcoholic dependence:

(1) Never take a drink when you "need" one.

(2) Sip slowly and space your drinks, the second drink 30 minutes after the first, the third an hour after the second and, never a fourth.

(3) Dilute the alcohol. Have a long, weak drink—never on the rocks, never straight and never, never out of the bottle.

(4) Keep an accurate and truthful record of the amount and number of drinks you take. Don't take a drink every day. Be vigilant and alert about the amount of each drink, whether you mix it or your host does. Does it consist of 1, 2, or 3 ounces of alcohol, or was it poured without measure—"just a wee drop?"

(5) Never conceal the amount of alcohol you drink; instead, exaggerate it. If you say you drink twice as much as you think you do, this probably will be more nearly accurate.

(6) Do not drink on an empty stomach.

(7) Stop the practice of drinking on a signal. The signals are: "luncheon," "left office," "on the way home," "before dinner," "before bed," "meeting people," "celebrating," and "to get me through." Substitute something in place of alcohol at these times, such as a big cup of hot, strong tea before dinner to refresh and energize (mountain climbers drink tea, not alcohol), a bowl of hot bouillon before lunch in place of a Martini; a cup of hot Ovaltine at bedtime; and, the habitual drinking of water. If one uses these beverages as alcohol substitutes he will feel better, be a better companion and enjoy happier evenings. Anything you can enjoy while drinking you can enjoy twice as much when sober. The use of some of these measures will interrupt the habit of "signal drinking."

(8) When tired or tense, soak in a hot tub and follow with a cold shower.

(9) Never take a drink to escape discomfort, either mental or physical.

(10) Never, never take a drink in the morning, thinking it will offset a hangover.

I don't know whether or not these rules will work on all of us social drinkers but they are worthy of thought.

2. *Acute Intoxication.* The first thing that must be done in this circumstance is to bring about sobriety. Sobriety is absolutely necessary if an approach to the over-all problems is to be effective.

Where should this sobering up program be carried out? In jail? In the home? In a hotel room? In a general hospital? In a state hospital for the mentally ill? Or in a hospital used specifically for the care of the alcoholic?

I believe the best place would be in a hospital for alcoholics where care is given by persons well qualified to recognize the needs of the alcoholic patient.

The worst place probably is in the alcoholic's home where no objective program can be carried out because of parental sympathy, the domineering demands of the patient and, in most instances, the lack of understanding of the patient by those in attendance.

In the sobering up period many approaches are used, almost any of which will be adequate if it includes nourishing food, mild to moderate sedation and a schedule of activity acceptable to the patient and one which can be carried out with firmness by those in attendance.

A program which I have found effective for many years is described below.

(a) A complete and detailed history and physical, remembering that the patient is first, an average person who can have any disease any other person can have. The history for the most part must be given by a member of the family or by friends and should include inquiry as to past history of peptic ulcer, bleeding, heart attack, previous illness and injuries; also, whether or not he has been on sedation (what kind, how often); amount of alcoholic beverages used; whether or not he has been hallucinating. A careful physical examination should be made. This should include blood pressure, heart and lungs; examination of the abdomen for liver enlargement or masses; examination for injury or for other disease signs.

(b) Withdrawal of alcohol in three days.

(c) Mild to moderate sedation.

(d) Good, wholesome, nourishing food.

One strict rule which I consider basic is that no patient goes home on sedation.

Another rule is that the patient is introduced to Alcoholics Anonymous when he is in an approachable condition.

Lest you gain the impression that I think the care of the acute alcoholic is really simple, I want to tell you that it is not. The problems are many and they try the patience of all in attendance.

3. *Rehabilitative or Follow-Up Care.* Herein lies the area in which most of the work is being done today. Also, herein lies the area regarding which there is so much controversy.

What is the best approach to the individual with a drinking problem?

Basically, if he did not drink again he would for the most part be mentally clear to solve the many psychological, sociological and economic problems which beset him.

Constant sobriety, although only one step in his return to normal living, is, neverthless, the biggest step and seemingly remains the greatest problem he has to solve. For without sobriety there is no way back to self and social acceptance.

Complete care of the alcoholic means a vast team effort, and demands the best of the patient, the physicians, the patient's family, Alcoholics Anonymous, employers (industry), social and religious agencies and other individuals and groups.

The importance of each is impossible to evaluate since the need for any one or the other would vary so greatly just as the specific need of each alcoholic varies. But we know that all are important if the alcoholic problem is to be met satisfactorily.

I shall discuss briefly some of the drugs now being promoted and used in the rehabilitative area of the alcoholic's care. These drugs for the most part are sedatives, tranquilizers, hypnotics and stimulants.

If chosen for use, they should, I believe, be used for only a short period and then under closest supervision.

So much research has been done and so much reading material reaches the physician that unless he looks a little deeper he may be led to believe that the drug described can cure all of the many problems of the alcoholic. Such is far from the case. Much of the research has been done on animals and in cases in which the human has been used, supervision of the patient leaves much to be desired.

Drugs being used today such as Librium, Sparine, Phenobarbital or other barbiturates tend to alter the personality of the individual, lower his reflex action, decrease his ability to discipline himself and, for the most part, do more harm than good. Any replacement for alcohol for the individual must help, not harm him, and I do not believe we have sufficient evidence to prove that drugs are the answer to the problem.

The stimulants, primarily the amphetamines, give the patient a false sense of well-being which is short lived unless he continues to take the drug indefinitely. They, like the barbiturates, have no place in the long-range management of alcoholism.

'Antabuse'

Last, but not least, a few words about the drug "antabuse."

Use of this drug is based on fear and the untoward symptoms which appear if the patient should imbibe alcoholic beverages while taking the drug. This situation could only increase anxiety in the poor, anxiety ridden person and, I believe, should not be employed. In fact, I believe its recommended use insults the intelligence both of the physician and patient.

Thus it will be seen, I believe, that drugs as such should play a very small part in the overall care of the alcoholic patient.

A Hand Up

Finally, a few words about an organization which has done as much as any group in the care of the alcoholic. It is solvent. It has not requested governmental financial assistance with resultant governmental control. That organization is Alcoholics Anonymous. These men and

women care for the alcoholic because they know how he feels, they know his trials and tribulations, his many weaknesses, his many strengths. They accept him for what he is and, in a measure, he finds security in an association which does not demand more than his willingness to try to live a normal, healthy life acceptable to self, God and society.

Some observers have suggested that as an organization, Alcoholics Anonymous believes that it has the answer for all the alcoholic's needs; if so, it is an empty belief. I do know, however, that none of these observers will minimize the work of Alcoholics Anonymous, and all of them without fail, list A.A. as one of the many effective approaches to the alcoholic problem.

There are many happy persons and families today because of Alcoholics Anonymous.

Summary

1. Despite the controversy concerning the causes of alcoholism, a definition that is usuable in the approach to the many problems involved and one that has found wide acceptance is as follows:

"Alcoholism is a chronic illness, psychic or somatic or psychosomatic, which manifests itself as a disorder of behavior. It is characterized by repeated drinking of alcoholic beverages, to an extent that exceeds customary dietary use or compliance with the drinker's health or his social or economic functioning."

2. It is the responsibility of medicine in its various field, psychology, social work and ancillary governmental and voluntary groups to meet the ultimate responsibility of each citizen on any problem. It remains, though, the ultimate responsibility of each citizen in any community in which such problem exists to demand provision and financing of adequate facilities.

The complete care of the alcoholic calls for a vast team effort between the patient, the physicians, the patient's family, A. A., employers (industry), social and religious agencies, and other individuals or groups.

3. I believe that the weakest link in our chain of over-all care is to be found in the area immediately after the drying-out period. That is, when the alcoholic must begin his readjustment phase of learning to live again with himself without alcohol, and with his family, his friends, his associates (if he still has a job), and society in general. It is in this area of his care that an all-out effort must be made to keep him under surveillance through cooperative efforts, if possible, but by compulsory measures, if necessary.

4. Drugs play an important part in the acute, intoxication phase of the treatment of the alcoholic, but only a minor role in the long-term care and even may create additional problems instead of helping him.

5. The alcoholic is, first, a person who can have any or all of the diseases the average person is heir to, besides his alcoholism and the sequelae therefrom.

6. Education of the individual must begin early in our educational system, if we are to acquaint the susceptibles with the danger inherent in alcohol.

7. We must concentrate our efforts on bringing about a semblance of order, and sense, and reason in our approach to the problems of alcoholism and to their solution.

All of this must be accomplished without losing sight of our only target—the individual alcoholic, that is, the person as a whole. Let's not divide him into so many parts or specialty areas that we find ourselves unable to put him together again; instead, let's approach him as an entirety and apply ourselves to the work of solving the numerous problems of the whole man.

In the field of medicine as in that of scientific endeavor, we have observed the trend toward specialization become so intensified and detailed that in many instances the patient as a whole becomes lost to sight—"we can't see the forest for the trees."

It was Lowell who said "Not failure, but low aim is crime." Let's go along with this and, in our care of the alcoholic patient, as in our care of the tuberculous, or of the diabetic, or of any patient at all, let our aim be high and our work go forward in the direction of our known goals.

Look how many ways

Thorazine®

brand of

chlorpromazine

can help

	Tranquilizer	Potentiator	Antiemetic
Agitation	●		
Alcoholism	●		●
Anxiety	●		
Cancer patients	●	●	●
Severe neurodermatitis	●		
Drug addiction withdrawal symptoms	●		●
Emotional disturbances (moderate to severe)	●		
Nausea & vomiting	●		●
Neurological disorders	●		
Obstetrics	●	●	●
Pain	●	●	●
Pediatrics	●	●	●
Porphyria	●	●	
Psychiatric disorders	●		
Hiccups—refractory	●		
Senile agitation	●		
Surgery	●	●	●
Tetanus	●	●	

'Thorazine' is useful as a specific adjuvant in the above named conditions.

The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information In SK&F literature or *PDR*. *Contraindications:* Comatose states or the presence of large amounts of C.N.S. depressants. *Precautions:* Potentiation of C.N.S. depressants may occur (reduce dosage of C.N.S. depressants when used concomitantly). Antiemetic effect may mask other conditions. Possibility of drowsiness should be borne in mind for patients who drive cars, etc. In pregnancy, use only when necessary to the welfare of the patient. *Side Effects:* Occasionally transitory drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; mild fever; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosage (in rare instances, may persist); weight gain; miosis; lactation and moderate breast engorgement (in females on high dosages); and less frequently cholestatic jaundice. Side effects occurring rarely include: mydriasis; agranulocytosis; skin pigmentation, lenticular and corneal deposits (after prolonged substantial dosages).

For a comprehensive presentation of 'Thorazine' prescribing information and side effects reported with phenothiazine derivatives, please refer to SK&F literature or *PDR*.

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A message from . . .

The President

THE CENTENNIAL YEAR

As this our 100th year comes into clear view, let's all look back at our heritage. What could we have done to have made it better? There is still some little time left—let's make an honest effort to really climax this *First Century of Medicine* in *West Virginia* by all knowing, at least, that we existed for 100 years and that some real good relationship existed between the members of the Association and the parent organization, the AMA. Many things and events happen for the betterment of medicine and our practice of it that are never known. To be sure, all of us—the American Medical Association and West Virginia State Medical Association—are on guard and do our best to further organized medicine and the members banded together under the State Medical Association and the AMA.

This being *The Year*, everyone please pitch in and help the Auxiliary to bring further glory to our State and ourselves—yes, AMA-ERF—the county secretaries have all the information.

"Mental Retardation Prevention and Potential"—a good meeting but will those who could use it best respond? Only time will tell.

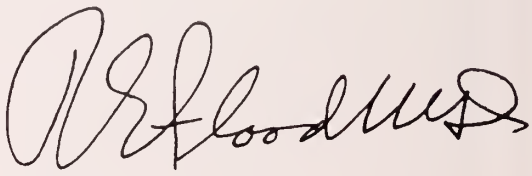
Then, there was the meeting to develop plans for the Centennial—see the reproduced medallion? And, thanks again to Mr. Mitchell Sagan, the Artist. Centennial plans are being formulated; keep abreast in *The Journal*, please.

The report of Council is found elsewhere in this issue. And, then there was Las Vegas—the nights were free to roam but the days were full of business; resolutions galore and not too important for anyone. It was perhaps just a coincidence, but so much publicity was had on sex—a good source of material on "The Strip."

Cabell County had a lovely Dinner Dance to which I was invited—nice affair, real Christmasy and what a Toastmaster!!! The Master Toaster himself, Jim Klumpp—and what a lovely painting I received. A winter scene which my Mom claimed for her room. Thanks, Jim. And thanks to Bettye and Al Esposito for their kind hospitality and to Joe Farrell and all the others who made the weekend so enjoyable for me.

When a doctor dies, wouldn't it be nice if some of his fellow physicians, plus a representative of a medical supply house and perhaps a lawyer, could get together, catalogue supplies, books and equipment and do all in their power to procure a buyer or the like? This could be a county society function—any suggestions gladly accepted and will be publicized.

Happy New Year in this our *Centennial Year*. May we all live holy, happily and healthy throughout it and many, many more.



RICHARD E. FLOOD, M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

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EDITORIALS

WHITE PAPER ON APPALACHIA—1966

The members of this Association are deeply concerned with the manner and means of implementing regional, area and community health centers as provided in the Appalachia Regional Act of 1965. The Commission has set aside sixty-nine million dollars for the construction and operation of demonstration health projects in those areas which are deemed qualified under the standards of need, desire and continued community support of the completed projects.

The guidelines for these projects were developed by a Health Advisory Committee of 25 members, established by the Commission by Resolution No. 43, only one of whom is engaged in the private practice of medicine. Three of the physicians on the Committee are officials of medical schools, and two are full-time officials with state governmental agencies. Several other members of the Committee are public health officials. The Advisory Committee was instructed to conduct a review of the health needs of Appalachia, to make recommendations concerning demonstration health facilities and to recommend criteria for evaluating project proposals under the Act. The Commission adopted the Advisory Committee's report verbatim and published it as a resolution under Section 202 of the Act.

In the very first sentence of the guidelines, which occupy some 4½ typed pages, is the statement of principle and the resolution that "each demonstration health facility project should have as its objective the phased development, through clearly defined steps, of comprehensive health services for all segments of the population in a designated area. Comprehensive health services for individuals and families include those essential components; health education, personal preventive services, diagnostic and therapeutic services, rehabilitative and restorative services, and community-wide environmental health services." It requires but a casual perusal to realize that these objectives cover the entire gamut of complete prophylactic and therapeutic health service demands of any community; further study, phrase by phrase, demonstrates the possibility of broad or narrow interpretation of these provisions. It readily becomes evident that wholehearted and general cooperation of the medical profession will be required in the development, implementation and operation of these facilities, despite the fact that but one private medical practitioner was a member of the committee which dictated the guidelines for medical participation. Nowhere in the guidelines was there any statement or resolve concerning the maintenance and continuance of our cherished patient-physician re-

lationship to the widest-deepest extent possible in a public health project.

The Council of the West Virginia State Medical Association met in special session in April, 1966, and adopted a resolution which called attention to the necessity of providing an equitable degree of representation in any body which promulgated regulations having such a general and binding effect upon the private sector of medical practice. A representative of the West Virginia State Medical Association was invited to state Council's views and position to the entire Health Advisory Committee. Very early in the discussion this representative was informed that it would be virtually impossible to insert another paragraph in the already-published guidelines, but the Committee did recognize the value of a definite statement of policy regarding the patient-physician relationship. On the next day we were notified that the following paragraph was recommended to the Commission as an insert in the preamble just prior to the "Therefore": "The purposes of these projects are to improve the general health of the area, to increase the availability of health services, and to demonstrate that it is possible to provide modern, comprehensive health care in a variety of regions in Appalachia with careful evaluation of each demonstration project. The development and operation of any community health services under Section 202 shall preserve and encourage all existing programs and arrangements involving the relationship between the physician and the patient."

This might be considered a rather effusive declaration of intent when but a simple statement regarding the preservation of the physician-patient relationship was requested; and secondly, it would have much more effect had it been placed in the "resolve" rather than the preamble, which is merely an introductory paragraph to a statement of intent.

As this portion of the "White Paper" is being written, it is learned that the Commission had appointed two more physicians from the private sector of medicine to its Health Advisory Committee and proposed to appoint two more physicians within a matter of days. These appointments are apparently the result of our conference in June, 1966, and constitute a definite step towards adequate medical representation at the national level. This representational distribution should be continued down through state and local levels.

It is now learned that on the spot studies and inspections have been completed in response to a proposal which originated at Ohio University in Athens, Ohio, and has been extended into a complex involving the University and two clinic and hospital groups in Gallipolis, Ohio; these two segments of the proposed complex are 75 miles apart. A lay group has already been incorporated to receive and dispense funds made available by the Regional Development Commission, the Department of Health, Education and Welfare and other possible sources.

It has been reported that final acceptance of the Ohio project may be accomplished before the end of the current year. It is also known that similar proposals are being considered in the states of North Carolina and West Virginia and Kentucky.

It must be admitted that neither organized medicine, the states, nor the various communities have accepted the challenge of leadership in this vital area, thus creating a gap or vacuum into which the federal government is moving. The process of creative federalism is already at work. The medical profession has an innate responsibility in the implementation and operation of the facilities, and with the acceptance of these responsibilities should be entitled to the privilege of adequate representation on national, state and local bodies which determine policy, authorize expenditures and direct the various phases of these public health projects.

The following is a Statement of Policy of the Council of the Ohio State Medical Association regarding the Proposed Southeast Ohio Appalachia Health Care Complex:

The Council pledges the wholehearted cooperation of the Ohio State Medical Association in any program intended to improve the health status of every citizen, so long as the program is developed and implemented in a manner equitable to everyone concerned and within the guidelines set forth in this Statement.

In order to assure the patient of quality medical care, any health care program must function within the following principles:

1. The program must in no way restrict, impinge on or interfere with the physician-patient relationship.

2. The program must be physician-directed and medically oriented.

3. The diagnostic, treatment and preventive factors must be determined and directed by the patient's attending physician, and by no third party.

4. The patient's desire for good medical care must be achieved through educational methods and not artifically created by a third party.

5. The determination of a patient's need for professional services must be made by the patient's physician.

6. The medical service content must serve as the core of the health care program, and all other health care services must be constructed around this core.

In keeping with these indispensable principles, The Council of the Ohio State Medical Association is seriously concerned with the following facts:

A. The guideline in Section 1, Resolution 62, of the Appalachia Regional Commission would deliver comprehensive health services to all segments of the population, regardless of economic status of the individual receiving the services. This is not realistic and is condemned in the sense that such a guideline will destroy the present concepts of the private practice of medicine.

B. The stated intent to provide comprehensive health care to the entire population is not within the intent of Congress as expressed in Section 2, Public Law 89-4. The intent expressed in this law is "* * * to assist the region in meeting its special problems, * * *" The provision of comprehensive health services to those persons who have the ability, or third party resources, to provide their own health care is not meeting a "special problem."

C. The medical services programs contemplated by Ohio Valley Health Services Foundation, Inc., must be planned, activated and supervised by practicing physicians endowed with policy-making authority, and with respect to these principles.

D. In the provision of medical care under any circumstances, the program must conform to the Principles of Medical Ethics and the Statutes of the State of Ohio.

We suggest the following resolution be adopted by the several state medical associations in Appalachia and forwarded to the individuals, officers and organizations named:

BE IT RESOLVED, That the Appalachian Regional Commission be advised that continued adequate representation from the private sector of practice of medicine on all pertinent national, state and local committees having cognizance of or control over the implementation and operation of health projects under Article 202 of the Appalachian Regional Commission Act of 1965, is not only desirable, but imperative if full cooperation between federal, state and local government and the medical profession is to be attained; and

BE IT FURTHER RESOLVED, That the manner of recommendation and selection of candidates for appointment to said committees shall be the joint responsibility of the governmental agencies involved and the various state medical associations or societies; and

BE IT FURTHER RESOLVED, That copies of this resolution shall be forwarded, with a covering letter, to the President of the United States, the Secretary of Health, Education and Welfare, the Appalachian Regional Commission, the senators, congressmen, and governors of each state in Appalachia, and to the president of each component county or district society in each state in Appalachia and to the American Medical Association; and

BE IT FURTHER RESOLVED, That the Executive Secretary of the West Virginia State Medical Association be directed to work with his counterpart in the Ohio State Medical Association to the end that a similar statement of policy shall be effected by all state medical associations in Appalachia.

TWO NEW BOOKS BY STATE PHYSICIANS

Journal readers are referred to "book reviews" for a report on two recent publications by West Virginia physicians. Dr. E. J. Van Liere, Dean Emeritus of the West Virginia University School of Medicine, has compiled a collection of delightful and instructive stories. Many of the articles will be of interest to our non-medical readers.

The Dean has been an active and regular contributor to *The Journal* for 30 years. He has written for *The Journal* many scientific essays, special articles, news items and editorials, some of which appear in "Medical and Other Essays." Doctor Van Liere has been a member of the Publication Committee for many years and his fellow members are delighted to receive his latest publication.

Dr. Joseph L. Curry and Dr. Willard J. Howland, Jr., give their readers an understanding of a highly scientific and ultra technical subject. The material in this volume should be a decided benefit to all hospitals equipped with personnel and machinery to carry out these complicated maneuvers.

GENERAL NEWS

Fall Meeting of the Council In Charleston on Nov. 20

The Fall meeting of the Council was held at The Daniel Boone Hotel in Charleston on Sunday, November 20, 1966, with the Chairman, Dr. Seigle W. Parks of Charleston, presiding.

Dr. Pat A. Tuckwiller of Charleston, Chairman of the Committee on Medical Education and Hospitals, appeared before Council to present a report on the one-day Medical Education Planning Conference which was held in Charleston on Sunday, November 13. He said that more than 75 persons, representing a large number of sections and affiliated societies as well as voluntary organizations, were present at the meeting.

He reported that much progress had been made by the Committee in its efforts to develop a program of continuing medical education for physicians practicing in the State.

White Paper On Appalachia—1966

Doctor Parks reported that he and Dr. James S. Klumpp had attended a meeting in Columbus on November 9 at the request of the Ohio State Medical Association. He said the purpose of the meeting was to discuss the criteria and guidelines adopted by the Appalachian Regional Commission for projects under Section 202 of the Appalachian Regional Development Act of 1965.

Following the meeting in Columbus, Doctor Klumpp said he prepared a "White Paper On Appalachia—1966" for approval by the Council. He read the "White Paper" as well as a resolution pertaining to the Appalachian Regional Commission.

The Council unanimously approved the "White Paper" and resolution and directed that both be published in *The Journal* (see page 23).

Comprehensive Health Planning Program

There was discussion concerning S. 3008, the Comprehensive Health Planning and Public Health Service Amendments of 1966, which was passed by the 89th Congress. The Council voted to recommend to Gov. Hulett C. Smith that the West Virginia Department of Health be designated as the State Agency for health planning functions under the provisions of the new law. Also, Council voted to recommend to the Governor that strong consideration be given to naming several practicing physicians to the Advisory Board.

Publication Committee Member Reelected

Dr. James S. Klumpp of Huntington was reelected a member of the Publication Committee for the term ending December 31, 1973. Doctor Klumpp is a Past President of the State Medical Association and is currently serving as Parliamentarian.

Third-Party Programs

Dr. George R. Callender, Jr., and Dr. Harry S. Weeks, Jr., Co-Chairmen of the Medical Economics Committee, presented a detailed report on the various third-party programs.

Doctor Weeks reported that members of the Joint Conference Committee had met with Commissioner L. L. Vincent of the Department of Welfare on November 9. He said the Commissioner assured the Committee that steps were being taken to speed up payment to physicians for services rendered to welfare recipients. He said there also was discussion concerning the large number of vouchers which have been returned to physicians in recent months.

Doctor Weeks also reported that Commissioner Vincent had called upon members of the Committee for assistance in helping to obtain the services of a physician for the position of medical director, either on a part-time or full-time basis.

The following members of the Council were present: Dr. Seigle W. Parks of Charleston, Chairman; Dr. Richard E. Flood of Weirton, President; Dr. Richard V. Lynch of Clarksburg, President Elect; Dr. Richard W. Corbitt of Parkersburg, Vice President; Dr. Ken-

These three physicians are the chief planners for the 100th Annual Meeting of the West Virginia State Medical Association which will be held in August. From left to right are: Dr. Ray S. Greco of Weirton, Chairman of the Committee planning the scientific program; Dr. Richard E. Flood of Weirton, President of the Association; and Dr. J. P. McMullen of Wellsburg, Chairman of the Committee for 100, which is arranging special Centennial events.

neth G. MacDonald of Charleston, Treasurer; Drs. Joseph L. Curry, Wheeling; Maynard P. Pride, Morgantown; R. L. Chamberlain, Buckhannon; Andrew J. Weaver, Clarksburg; I. Ewen Taylor, Huntington; William E. Gilmore, Parkersburg; Buford W. McNeer, Hinton; A. J. Villani, Welch; W. P. Bittinger, Oak Hill; George R. Callender, Jr., Charleston; and Mr. William H. Lively, Secretary ex-officio, and Mr. Edward D. Hagan, Executive Assistant.

The meeting also was attended by Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. C. A. Hoffman of Huntington, AMA Delegate; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. George F. Evans of Clarksburg, Editor, *The West Virginia Medical Journal;* Dr. James S. Klumpp of Huntington, Parliamentarian; Dr. N. H. Dyer of Charleston, Director of the State Department of Health, Dr. Harry S. Weeks, Jr., of Wheeling, Co-Chairman of the Committee on Medical Economics; Dr. Pat A. Tuckwiller of Charleston, Chairman of the Committee on Medical Education and Hospitals, and Dr. J. Dennis Kugel of Charleston.

PG Course in Clinical Allergy

A postgraduate course entitled "Newer Aspects of Experimental and Clinical Allergy" will be conducted in Boston, Massachusetts, January 30 through February 3.

The course is sponsored by the American College of Physicians. Registration fees include $60 for ACP members and $100 for nonmembers.

Additional information may be obtained by writing to Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

18 Physicians Licensed By Reciprocity

The following 18 physicians were licensed by reciprocity to practice medicine in the State of West Virginia at a meeting of the Medical Licensing Board which was held in Charleston on October 17, 1966:

Carhart, James Milton, Philippi
Conner, Garret Harding, Morgantown
Glasgow, Jean M. M., Roanoke, Virginia
Halliday, Tom Dunbar, Marietta, Ohio
Hansen, Robert William, Welch
Hobbs, Robert Knowles, Chester
Juberg, Richard Caldwell, Morgantown
Julias, George Stephen, White Sulphur Springs
LaPlante, Eugene Schrae, Morgantown
Lapp, Norman LeRoy, Morgantown
Light, John Paul, Cumberland, Maryland
Newman, William Randolph, Cumberland, Maryland
Roberts, Robert Ellis, Petersburg
Schwartz, Willard Chester, Pittsburgh, Pennsylvania
Smith, John Joseph, Morgantown
Spencer, Frederick Arthur, Jr., Salem
Thomas, Terrence Joseph, Berkeley Springs
Russakoff, Alex David, Morgantown

The next meeting of the Medical Licensing Board will be held in Charleston on January 9-11, 1967, for the purpose of licensing physicians by direct examination and reciprocity.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

The Committee for 100 met in Charleston on Saturday, November 19, to plan for special events to be held at the Centennial Meeting of the West Virginia State Medical Association at The Greenbrier in August. Seated (left to right) are: Dr. James S. Klumpp of Huntington; Dr. Richard E. Flood of Weirton, President of the State Medical Association; Dr. J. P. McMullen of Wellsburg, Chairman; and Dr. B. B. Richmond of Beckley. Standing are: Dr. Ray S. Greco of Weirton, Chairman of the Program Committee; Mrs. McMullen; Mrs. Greco; Dr. L. J. Pace of Princeton; Mrs. Pat A. Tuckwiller of Charleston; Dr. Frank J. Holroyd of Princeton; Mrs. Hu C. Myers of Philippi, President of the Woman's Auxiliary to the State Medical Association; Dr. Thomas G. Reed of Charleston; Dr. E. Lyle Gage of Bluefield; Dr. George F. Evans of Clarksburg; Dr. Joseph L. Curry of Wheeling; and Dr. William L. Cooke of Charleston.

West Virginia Medicine

(1876-1900)

In keeping with their intentions to publish a brief history of the West Virginia State Medical Association, the editors of *The Journal* herewith present a sketch of organized medicine in West Virginia from 1876 to the turn of the century.

In the current installment we find physicians of that era engaged in campaigns against medical quacks and charlatans. We also find a high degree of talent and eloquence among the medical essayists and speakers of that day. —The Publication Committee.

★

According to the Medical Register of 1876, there were only seven county medical societies in West Virginia at that time. However, there seems to have been many irregular practitioners who, although ineligible for membership in the State Society could obtain a license to practice. In 1875, the State Board of Health or any two members in a district were empowered to grant a practice license to any graduate of a reputable school or to any person who had practiced medicine within the State for 10 years. Any itinerant physician could pay a special tax of $50 per month to the county sheriff and set up his pitch anywhere within that county. West Virginia attracted patients and physicians from afar because of the enormous interest in the state spas.

Before the turn of the century there were 38 health resorts where the sick could "take the waters." The choice was remarkable. There were blue, green, grey, white, red, sweet and sulphur springs.

In 1896, the Medical Society of West Virginia held its annual meeting in Wheeling and Dr. J. D. Campbell presided. Eighty-two members answered the roll call. This was the 29th Annual Meeting of the West Virginia State Medical Society. The President recommended at this date that a history of the Society should be prepared for the archives. Unfortunately for the Publication Committee, this was not done. The presidential address ended with this delightful paragraph:

> "Let us love our Society because of its great possibilities of good. Medical men do not realize fully their influence upon communities in which they live. They can mould public opinion on matters of public health with an ease which is not surpassed even by the ministers of God in regard to religion. Let the physicians of any community all unite in advocating any reform of scientific medicine and no power can stay that reform if they will but urge it earnestly. The difficulty in the past has always been that in spite of our societies we are a lot of disjointed fragments, where we should be a homogeneous whole. We must change all that. Let us see to it henceforth that this Society shall be what the ideal medical society should be—a

crucible where the thoughts and the energies of the many are fused into one common thought and one common force. I repeat it, let us resolve to attend every meeting of the Society in spite of the obstacles that may arise to prevent us. Let us look forward to those meetings as to the great event of the year—as to a yearly renaissance of our profession's greatness and power in the State. Let every year find us in closer touch with each other mentally, scientifically and socially than we were the year before, and with an ever growing sense of the bond of brotherhood that claims us all; with an ever deepening faith in our profession and its noble ends and aims to tangible results that shall rebound to the benefits of science and of human kind."

Dr. L. D. Wilson of Wheeling read an eulogy to the honor of the late Dr. James E. Reeves, one of the founding fathers of the Society. Many years prior to death, Doctor Reeves had left West Virginia to practice in Tennessee. It is of interest that he was, also, one of the founders of the American Public Health Association and President of that society in 1885. The record contains a list of the contributions of Doctor Reeves, comprising many local and national publications. There also were papers by Dr. Harriet B. Jones concerning the "Woman Physician" and a scholarly philosophical, physiological essay on "Positivism in Medicine" by Dr. R. W. Hazlett of Wheeling.

There were now 350 members of the Society.

The 33rd Annual Session of the Medical Society of the State of West Virginia was held in Morgantown, May 9-11, 1900, with Dr. C. S. Hoffman in the chair. Only 48 members answered the roll call. Doctor Hoffman urged greater activity by the State Board of Health in the suppression of charlatans. His definition of the word was all inclusive. Osteopaths, faith healers and especially the Christian Scientists were charlatans to Doctor Hoffman. The President strongly advocated the establishment of a state hospital for the treatment of tuberculosis (Action was taken by the Legislature 13 years later).

In 1900, for the first time we find that old sidewinder, a committee to report on the President's address, which, because of tradition, was continued until the House of Delegates wearied of such a procedure. For some unfathomable reason, the House of Delegates resurrected the procedure in 1965.

The essayists were all physicians of great talent and a reading of their manuscripts would indicate the Society could have done no better by bringing in visiting firemen. As proof of the high level of intelligence shown in the manuscripts, the Publication Committee was asked to furnish each year 50 copies of the "Transactions" to the Association of American Libraries.

These wise old doctors passed a resolution which has not been fulfilled in 65 years, but over the years might have saved the State a lot of grief, to wit:

"Resolved, That the Committee on State Medicine be instructed to take steps at once to draft and urge the enactment of a law which shall give proper recognition to the reputable medical profession of the State in the matter of strictly medical appointments, and shall give them consideration in the appointment of Boards having control over State Institutions."

This was unanimously adopted.

(TO BE CONTINUED)

Education Planning Conference Termed Successful

More than 70 physicians and lay people attended the Medical Education Planning Conference which was neld in Charleston on November 13 under the sponsorship of the Committee on Medical Education and Hospitals of the West Virginia State Medical Association.

Dr. Pat A. Tuckwiller of Charleston, Chairman of the Committee, termed the Conference a success.

The morning session included addresses by Dr. Richard V. Lynch, Jr., of Clarksburg, President Elect of the Association; Dr. Clark K. Sleeth of Morgantown, Dean of the West Virginia University School of Medicine; Dr. David Z. Morgan of Morgantown, Assistant Dean; and Dr. Daniel Hamaty of Charleston, Director of Medical Education at Charleston Memorial Hospital.

Dr. Edward G. Stuart of Morgantown, Vice President of the WVU Medical Center, also had been scheduled to speak, but he had to cancel because of illness.

The afternoon session was devoted to a question-and-answer period and a general discussion of the Committee's plans to establish a coordinated program of postgraduate medical education for practicing physicians of the State. These plans received general endorsement from representatives of more than 30 hospitals and professional and voluntary health organizations who were present.

The following groups were among those represented:

Broaddus Hospital in Philippi; Wheeling Hospital; the Parkersburg Educational Foundation; West Virginia Division of the American Cancer Society; the Cancer Committee of the State Medical Association; the West Virginia Academy of Ophthalmology and Otolaryngology; Appalachian Regional Hospital in Beckley; the West Virginia Heart Association; and the West Virginia Association for Mental Health.

The West Virginia Tuberculosis and Health Association; the State Department of Health; West Virginia Society of Anesthesiology; Charleston General Hospital; West Virginia University School of Medicine; Beckley Hospital; the West Virginia Obstetrical and Gynecological Society; and the American College of Surgeons.

The Section on Neurology, Neurosurgery and Psychiatry of the Association; the West Virginia Pediatric Society; West Virginia Public Health Association; St. Mary's Hospital in Huntington; Cabell-Huntington Hospital; Charleston Memorial Hospital; West Virginia State Society of Allergy; Thomas Hospital of South Charleston; and the West Virginia Radiological Society.

West Virginia Department of Mental Health; West Virginia Diabetes Association; St. Mary's Hospital in Clarksburg; Section on Surgery; West Virginia Chapter of the American Academy of General Practice; the West Virginia Hospital Association and the Hospital Planning Council.

The Committee on Medical Education and Hospitals will meet on January 8 to review suggestions made at the Conference. At that time, it is expected to take additional steps toward implementing the postgraduate program.

Copies of the proceedings of the Medical Education Planning Conference will be available in January. They may be obtained by writing to Dr. Pat A Tuckwiller, West Virginia State Medical Association, P. O. Box 1031, Charleston, West Virginia.

Speakers at the Medical Education Planning Conference in Charleston on November 13 included these members of the West Virginia State Medical Association. Standing is Dr. Pat A. Tuckwiller of Charleston, Chairman of the Committee. Others from left to right are: Dr. Richard V. Lynch, Jr., of Clarksburg, President Elect of the West Virginia State Medical Association; Dr. Daniel Hamaty of Charleston; Dr. Clark K. Sleeth of Morgantown, Dean of the WVU School of Medicine; and Dr. David Z. Morgan of Morgantown, Assistant Dean (Photo Courtesy The Charleston Gazette).

Cleveland Clinic Schedules Postgraduate Courses

The Cleveland Clinic Educational Foundation will conduct four postgraduate courses during January and February.

The schedule is as follows:

January 11-12—Advances in Dermatology.

January 18-19—Controversies in General Surgery.

February 1-2—General Practice.

February 15-16—Perspectives of Electophoresis and Clinical Chemistry.

Additional information may be obtained by writing to: Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

Dr. J. H. Anderson Honored By Welch Chamber

Dr. J. Howard Anderson, President of the West Virginia State Medical Association in 1921, was named Welch's "Man of the Year" at the annual dinner of the Welch Chamber of Commerce on December 1.

The honor was the latest of many for Doctor Anderson. He was named "Doctor of the Year" in 1956, and the following year, he was "General Practitioner of the Year."

This is the second consecutive year that the Welch Chamber of Commerce has bestowed the "Man of the Year" honor on a physician. Last year, Dr. A. J. Villani was cited.

PG Course in Blood Diseases

The American College of Physicians will conduct a postgraduate course in "Current Concepts in Blood Diseases" in Miami Beach, Florida, January 22-27.

Fees include $60 for members of the ACP and $100 for non-members.

Additional information may be obtained by contacting Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

W. Va. Heart Association Offers Materials for Patients

The West Virginia Heart Association has announced the availability of a new Physician's Prescription for Material of the Heart Association. The form can be used when the physician feels that a certain Heart Association publication can be helpful to his patient.

Some booklets and pamphlets can be obtained by the patient only through a doctor's prescription. Among these are the various diet booklets such as: "Your 500 mg Sodium Diet"; "Your 1000 mg Sodium Diet"; and "Your Mild Sodium Restricted Diet." In addition, several stroke booklets are offered only on a prescription basis. Among these are "Strike Back at Stroke," "Up and Around Again," and others.

In addition, many of the non-prescription publications of the Heart Association are listed on the form so that the physician can make pertinent information available to individual patients. Physicians throughout the state will receive an initial supply of the special prescription forms. Further information or additional forms may be obtained by contacting the West Virginia Heart Association, 759 Washington Street, West, Charleston, West Virginia 25302.

The first person to register for the Medical Education Planning Conference was Dr. Hu C. Myers of Philippi. Doctor Myers represented Broaddus Hospital.

The State Medical Association was host at a luncheon between the morning and afternoon sessions of the Medical Education Planning Conference. Shown here are Dr. Andrew W. Goodwin II and Dr. W. Alva Deardorff, both of Charleston and both representatives of the West Virginia Radiological Society.

3,926 New Cancer Cases Reported in State

During the past year, West Virginia had 3,926 new cases of cancer diagnosed from 50 West Virginia hospitals and submitted to the Central Cancer Registry, according to State Health Director N. H. Dyer. Doctor Dyer noted that half of this number did not seek medical care until the disease was no longer localized.

In a recent issue of the "State of the State's Health," Doctor Dyer reported the highest number of new cancer cases, 913, were in the age bracket 55-64. A total of 906 cases were diagnosed in the 65-74 age group and 655 cases were discovered in the under-45 age group. The health official said it was difficult to think of cancer as a disease of old age when there were only 26 more cases in the age group 75 and over than there were in the group under 45.

"The daily battle against cancer is being waged through education—providing the population with the necessary information to combat cancer," Doctor Dyer said. "The motivating principle of cancer detection is that diagnosis and treatment at the earliest possible stage gives maximum opportunity for cure."

Fifty years ago a diagnosis of primary lung cancer was a rare event, but during the past two decades the disease has emerged from obscurity to become an important cause of death, Doctor Dyer pointed out. Several possible explanations, most popularly cigarette smoking, industrial carcinogens, and atmospheric pollution, are under investigation. Perhaps, Doctor Dyer commented, no other field of cancer investigation has stirred up a more active controversy or one with such far-reaching personal, social, and economic implications.

In West Virginia last year, Doctor Dyer observed, 369 new cases of lung cancer were confirmed by pathology, but only 75 were still localized at the time of diagnosis. There were 16 localized cases in the age group 45 and under, with the largest number of cases in the 55-64 range.

Statisticians estimated there would be 5,000 new cancer cases in West Virginia in 1965. Since 3,926 cases were admitted to local hospitals, Doctor Dyer remarked, it would appear that the estimate is fairly close. And, he added, we are facing the same grim estimate for 1966. Approximately 1,000 of these cases will be divided between cancer of the breast and cancer of the cervix.

At this point, the last chapter of these 5,000 cases is yet to be written, Doctor Dyer said. Whether they will end in tragedy, or another example of cure through early diagnosis and treatment, is the concern and responsibility of our official and voluntary agencies and the physicians of our state.

"The key to success in the fight against cancer," Doctor Dyer concluded, "is to make self-concern and self-responsibility the weapons by which each of our citizens may help himself."

In another issue of "The State of the State's Health," Doctor Dyer reported that the passage of the regulation requiring laboratories to report reactive tests for syphilis in February, 1965, had contributed greatly to the success of the West Virginia Venereal Disease Program.

During fiscal year 1966, 55 per cent of the infectious syphilis cases reported to the Department of Health resulted from follow-up performed on reactor reports, Doctor Dyer noted. This figure surpassed the national average by 20 per cent and represented an increase of 134 per cent when compared to fiscal 1965.

Doctor Dyer said that syphilis cases totaling 1,677 (all stages) were identified this year through the reactor program and reported for the first time. This was an increase of 415 cases over the 1,262 cases recorded in fiscal 1965.

The health official remarked that reports are now being received from 100 per cent of the 135 private and public laboratories known to be processing serologic tests for syphilis within the state.

The 9,389 reactors reported to the Department of Health during the year constituted an increase of 119 per cent when compared to the previous high of 4,289 reports received in fiscal year 1965, Doctor Dyer pointed out. Over 96 per cent of the reactor reports were followed to a satisfactory medical disposition.

According to Doctor Dyer, a total of 2,792 reactors required follow-up during the first nine months of fiscal 1966, and approximately 75 per cent of the follow-up activity were completed within two weeks after reports were received.

"Now that the reactor program is operating smoothly and effectively," Doctor Dyer said, "There is still another step which must be taken by physicians if this disease is to be banished." "A routine serologic test for syphilis should be performed for all patients

Status of Bills Reported In Legislative Bulletins

Complete reports concerning action by the Legislature on bills of interest to the medical profession are incorporated in "Legislative Bulletins" that will be sent frequently to members of the Association. The regular 60-day session opens January 11.

The Bulletins that will be mailed from the headquarters offices of the State Medical Association are timed so as to take advantage of report dates by key committees and subsequent action by the Senate and House of Delegates.

Through the use of Bulletins, we will continue to bring to our members as promptly as possible up-to-the-minute activities. These reports are, in effect, news stories that are being prepared and distributed in lieu of lengthy stories that would ordinarily appear in *The Journal*.

The final Bulletin will be mailed within a day or two after adjournment of the Legislature.

admitted for medical observation. The most effective reactor program cannot prevent the destruction and costly effects of syphilis unless those persons harboring the disease are given the initial serologic test for syphilis."

Dr. C. A. Hoffman to Speak At AMA Congress

The American Medical Association will sponsor its First National Congress on the Socio-Economics of Health Care in Chicago, January 22-23.

Dr. C. A. Hoffman of Huntington, a member of the AMA Council on Medical Service, will participate in a panel on "Financing Health Care Services" on Monday, January 23. Doctor Hoffman's topic will be "Evolution and Perspective."

Other speakers will examine in depth the current health status of the American people; the impact of medical and social changes upon patterns of health care; the changing role of the hospital and its medical staff in the community; and new resources and methods in training and utilization of health manpower.

The Congress is sponsored by the AMA Council on Medical Service and the Division of Socio-Economic Activities.

Additional information may be obtained by writing to the Division of Socio-Economic Activities, Department of Health Care Services, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

ACP Plans Tri-State Meeting In Morgantown

The American College of Physicians will conduct a regional meeting at the West Virginia University Medical Center in Morgantown, January 20-21.

Edmund B. Flink, M. D.

The session, for members in West Virginia, Western Pennsylvania and Ohio, is one of 30 scientific sessions sponsored each year by the ACP throughout the United States and Canada. They are designed to help members keep abreast of developments in the basic sciences and clinical medicine.

Dr. Rudolph H. Kampmeier of Nashville, Tennessee, President Elect of the ACP and Professor of Medicine Emeritus at Vanderbilt University School of Medicine, will be a special guest.

The meeting is under the general direction of Dr. Edmund B. Flink, ACP Governor for West Virginia and Chairman of the Department of Medicine at the WVU School of Medicine; Dr. Richard W. Vilter of Cincinnati; and Dr. William W. Cooper of Pittsburgh.

Dr. Merle S. Scherr of Charleston, President of the International Doctors' Children Exchange, entertains his four young visitors, all children of Mexican physicians. With Doctor Scherr are: Lorenzo G. Ulloa, 12; Andres A. Schuneman, 14; Oscar E. Morett, 13; and Ernesto H. Lugo, 14.

Charleston Doctors Join Children's Exchange

Four children of Mexican physicians recently completed a six-week stay in the homes of Charleston physicians under a recently organized international children exchange program.

Dr. Merle S. Scherr of Charleston is President of the new International Doctors' Children Exchange (IDCE). Other Charleston hosts are Drs. D. G. Hassig, J. Paul Aliff and Thomas G. Potterfield. The children, all of whom can speak some English, attended school while living in Charleston.

They are the sons of a general surgeon, a pediatrician, an orthopedic surgeon and a plastic surgeon in Mexico.

The program had its beginning last summer when the Scherr family was visiting Mexico. Doctor Scherr fell and broke an arm, and during his treatment, he developed a friendship with his Mexican doctors.

Efforts are being made to extend the exchange program to include Italy, Switzerland, France, England, Denmark, Norway, Sweden and Germany.

West Virginia doctors who would like their children to participate in the exchange should contact Doctor Scherr at 805 Atlas Building, Charleston.

Spring Congress in Oph.-Otol.

The Gill Memorial Eye, Ear, Nose and Throat Hospital will conduct its 40th Annual Spring Congress in Ophthalmology and Otolaryngology in Roanoke, Virginia, April 3-7, 1967.

Additional information may be obtained by writing to the Superintendent, P. O. Box 1789, Roanoke, Virginia.

Dr. Albert C. Esposito Heads SMA Council

Dr. Albert C. Esposito of Huntington, a Past President of the West Virginia State Medical Association, was elected Chairman of the Council of the Southern Medical Association during the 60th Annual Meeting in Washington in November.

Albert C. Esposito, M. D.

Doctor Esposito formerly served as Vice Chairman of the Council and Chairman of the Committee on Medical Students.

Doctor Esposito also serves on the Executive Committee of SMA's Section on Ophthalmology.

The new President of SMA is Dr. Guy T. Vise of Meridian, Mississippi. He was installed at the President's Night Annual Dinner Banquet.

Doctor Vise is Clinical Instructor, Department of Preventive Medicine, University of Mississippi Medical Center in Jackson. He is a graduate of the University of Tennessee.

Dr. Oscar B. Hunter, Jr., of Washington, was named President Elect.

Other new officers include:

Dr. Donald Marion of Miami Beach, Florida, First Vice President; and Dr. William P. Herbst III of Washington, Second Vice President.

The four-day meeting attracted about 4,000 physicians from 16 southern states and the District of Columbia. The 1967 meeting will be held in Miami Beach, Florida, November 13-16.

PMA Chairman Sees Rise In Bootleg Drugs

Prohibition-style racketeers are beginning to invade the prescription drug market under cover of pressure for lower pices, accoding to Lyman C. Duncan, Chairman of the Pharmaceutical Manufacturers Association.

In a speech to the National Association of Retail Druggists, Mr. Duncan warned that a rising tide of "bootleg drugs" could impose a task on Food and Drug Administration Agents as difficult as that of revenue agents searching for bootleg stills in Prohibition days.

He said the protection once afforded doctors and their patents by the manufacturer's name on his products is "in danger of being demolished" by governmental action to promote the use of unbranded, and presumably cheaper, drugs.

Mr. Duncan said "pistol-packing investigators" will have to search for the illicit and shading operators turning out complex and dangerous drugs in the industrial fringes of New Jersey and the outskirts of such cities as Chicago and Detroit.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1967

Jan. 14-19—Am. Acad. of Orthopaedic Surgeons, San Francisco.
Jan. 20-21—ACP Regional Meeting, Morgantown.
Jan. 22-23—AMA Nat. Cong. on Socio-Economics of Health Care, Chicago.
Jan. 23-25—Soc. of Thoracic Surgeons, Kansas City.
Jan. 31-Feb. 4—Am. Col. of Radiology, Los Angeles.

Feb. 8-10—Am. Acad. of Occupational Med., San Francisco.
Feb. 9-15—AMA Cong. on Med. Ed., Chicago.
Feb. 14-19—Am. Col. of Cardiology, Washington.
Feb. 18-22—Am. Acad, of Allergy, Palm Springs, Calif.
Feb. 23-25—Cen. Surg. Assn., Pittsburgh.
Feb. 28—Nat. Multiple Sclerosis Soc., New York.

March 9-11—AMA-ABA National Medicolegal Symposium, Miami Beach.
March 10-11—AMA Conf. on Rural Health, Charlotte, N. C.
March 16-18—Sou. Soc. of Anesthesiologists, Charleston, S. C.
March 19-24—Southeastern Surgical Cong., Bal Harbour, Fla.
March 19-24—Am. Col. of Allergists, New Orleans.

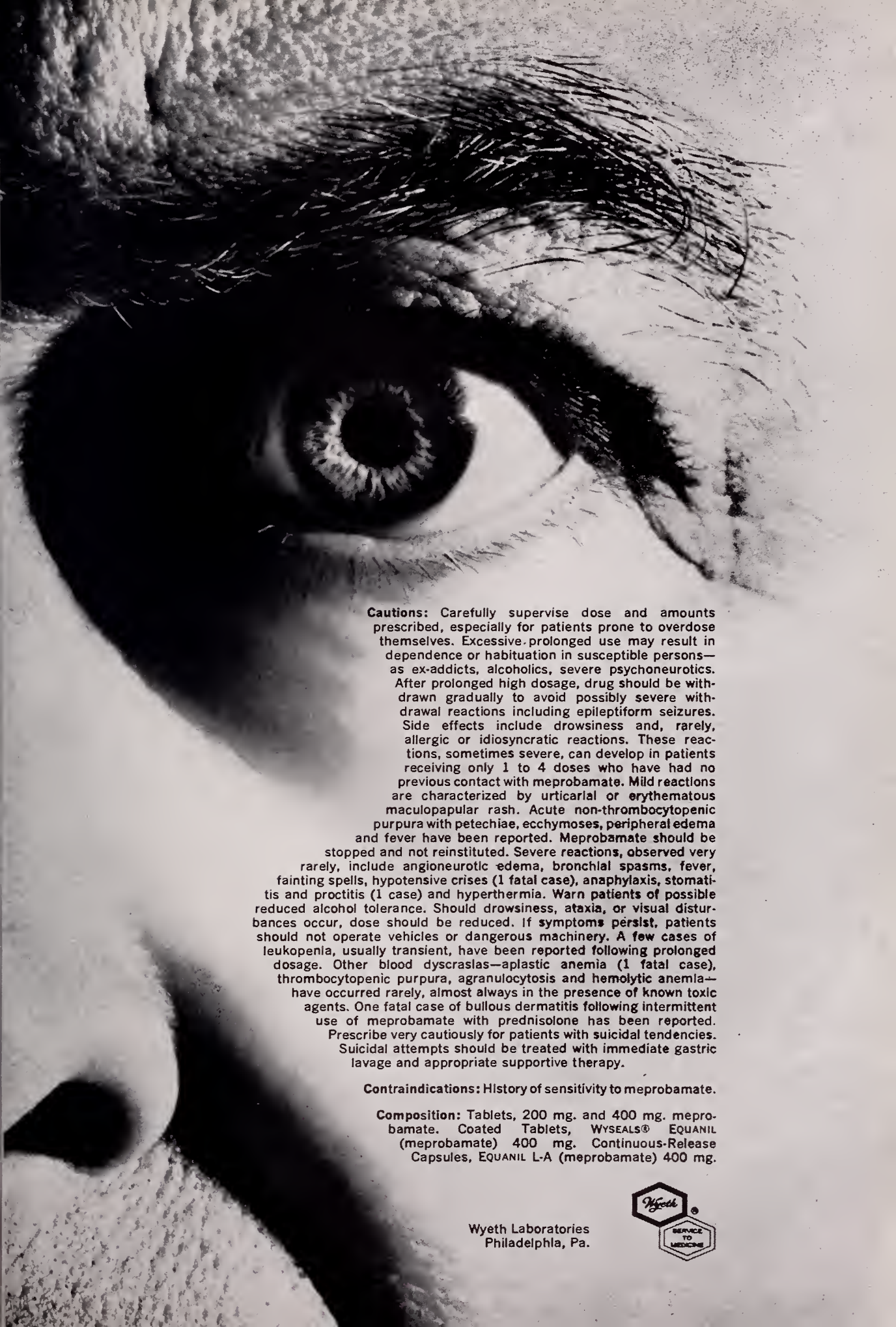
April 3-5—Am. Acad. of Ped., San Francisco.
April 7-9—Am. Soc. of Int. Med., San Francisco.
April 10-13—Indus. Med. Assn., New York City.
April 10-14—Am. Col. of Physicians, San Francisco.
April 11-13—Am. Surg. Assn., Colorado Springs.
April 17-20—Am. Col. of Ob. and Gyn., Washington.
April 17-19—Am. Assn. for Thoracic Surgery, New York.
April 19-21—Maryland Medical, Baltimore.
April 23-26—W. Va. Acad. of Oph. and Otol., White Sulphur Springs.
April 24-26—AMA Nat. Cong. on Environment Health Management, New York City.
April 27-28—Am. Ped. Soc., Atlantic City.
April 30-May 2—W. Va. Chapter, AAGP, Huntington.
April 30-May 5—Int. Col. of Surgeons, Bal Harbour. Fla.

May 2-3—Assn. of Am. Phys., Atlantic City.
May 3—Am. Cancer Soc., Dallas.
May 4-6—Am. Gynecological Soc., Phoenix.
May 6—Am. Col. of Psychiatrists, Philadelphia.
May 7-12—Am. Psy. Assn., Detroit.
May 11-14—Am. Surg. Assn., Colorado Springs.
May 16-19—Ohio Medical, Columbus.
May 28-June 1—Am. Dermatological Assn., Colorado Springs.
May 29-31—Am. Oph. Soc., Hot Springs, Va.
May 29-June 1—Am. Urol, Assn., New York.
May 21-24—Am. Thoracic Soc., Pittsburgh.

June 15-17—Am. Col. of Chest Phys., Atlantic City.
June 16-17—Am. Geriatrics Soc., Atlantic City.
June 17—Acad. of TB Phys., Atlantic City.
June 17-18—Am. Diabetes Assn., Atlantic City.
June 18-22—AMA Annual Con., Atlantic City.
June 26-29—Am. Orthopaedic Assn., Hot Springs, Va.
July 14-15—Rocky Mtn. Cancer Conf., Denver.

Aug. 24-26—100th Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.

Aug. 27-Sept. 1—Am. Acad. of Phys. Med. & Rehab., Miami Beach.
Sept 29-Oct. 1—W. Va. Heart Assn., Wheeling.



Cautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

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WVU Medical Center
—News—

Two additional appointments to the faculty of the West Virginia University School of Medicine have been announced by Dr. Harry B. Heflin, Acting President of WVU.

Dr. Warfield Garson of Bethesda, Maryland, has been named Clinical Professor of Preventive Medicine, and Dr. Reverdy H. Jones of Fairmont has been appointed Clinical Assistant Professor of Medicine.

Doctor Garson, who also serves as Assistant Chief of the Division of Occupational Health, U. S. Public Health Service, is a graduate of the University of California at Los Angeles. He received his M. D. degree in 1945 from the University of Southern California.

Doctor Jones, a native of Virginia, received his B. S. degree from Virginia Military Institute. He received his M. D. degree in 1938 from the University of Virginia.

Doctor Van Liere Publishes Book

A collection of essays on medical and other subjects has been published in commemoration of West Virginia University's Centennial celebration by Dr. Edward J. Van Liere, Dean Emeritus of the WVU School of Medicine.

The book, *Medical and Other Essays*, was made possible by a grant from the West Virginia University Foundation. Copies may be obtained by writing to the Foundation.

"Since I have been in an academic atmosphere all my life and have been trained in and have taught biological sciences including medicine, many of these essays are slanted toward biology," Doctor Van Liere wrote in the preface.

Many of the essays have appeared previously in such publications as the *Harvard Medical Journal, The Baker Street Journal, The West Virginia Medical Journal, The Bulletin of the American College of Physicians*, and *The Archives of Internal Medicine.*

Most of the 30 essays treat fields with which Doctor Van Liere is closely associated, but he expands the scope of the work by also writing about such subjects as retirement, creative thinking, Boswell, Samuel Johnson, Stonewall Jackson and Sherlock Holmes.

Doctor Van Liere joined the School of Medicine in 1921 and was appointed Dean of the School in 1935, serving in that capacity until 1961. He retired from the faculty last Summer, but he continues to be active in writing and research.

• Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.

Resigns from Medical Center Staff

Mr. Arthur V. Ciervo, Director of News and Information Services at the Medical Center since October of 1964, has resigned to accept another position.

On December 1, Mr. Ciervo became a science writer on the public relations staff at Georgetown University. No successor has been named.

Visiting Lecturers

Dr. John C. Gallagher of Washington, D. C., lectured at the Medical Center on December 12.

His topic was "Normal Gross Anatomy and Microanatomy of the Temporal Bone and Micropathology of the Temporal Bone."

Doctor Gallagher is Chief of Otolaryngologic Pathology at the Armed Forces Institute of Pathology in Washington. He is author and co-author of several publications on pathology.

His visit was sponsored by the Division of Otolaryngology of the School of Medicine.

Dr. Seymour L. Friess presented a paper on December 16 as part of "Biochemistry: 1967," a series of monthly seminars presented by the Department of Biochemistry.

Doctor Friess' paper was entitled "Biochemical Probing of Synaptic Excitation and Blockade Mechanisms in Cholinergic Tissues."

For 15 years, Doctor Friess has been associated with the Naval Medical Research Institute in Bethesda, Maryland, where he is head of the Biochemistry Division and Acting Director of the Physiological Sciences Department.

Dr. Murry C. Brown, Chief of the Division of Occupational Health, U. S. Public Health Service, Bureau of State Services, presented an address at the Medical Center on December 2.

His topic was "Health from the Federal Level." Doctor Brown's visit was sponsored by the Division of Preventive Medicine in the WVU School of Medicine.

In 1939-40, he was director of the Venereal Disease Control Program in Logan County.

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Don Phillips, Administrator
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AFFILIATED CLINICS

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David M. Wayne, M. D.

Beckley Mental Health Center
109 E. Main Street, Beckley, W. Va.
W. E. Wilkinson, M. D.

Charleston Mental Health Center
1206 Quarrier St., Charleston, W. Va.
E. E. Gimenez, M. D.

Mental Health Clinic
Professional Building, Wise, Va.
Pierce D. Nelson, M. D.

The Month in Washington

• **From the Washington Office of the American Medical Association.**

THE National Institutes of Health is concentrating its efforts in the artificial heart field to support of programs for development of auxiliary heart-pumping devices instead of a complete artificial heart.

The auxiliary device approach includes the programs led by Dr. Michael E. DeBakey of the Baylor University College of Medicine in Houston and Dr. Adrian Kantrowitz, Chief of Surgical Services at Brooklyn's Maimonides Hospital. Other teams working on developing complete artificial hearts will continue their research, but the government will not emphasize their approach.

The decision to forego for the present a major program to build a complete artificial heart was made by Dr. James A. Shannon, NIH Director, after he determined that not enough fundamental information existed on just how the heart operates to make such a project feasible.

Doctor Kantrowitz described the problems involved in designing artificial heart devices in a speech at a meeting of the American Society of Mechanical Engineers in New York.

"The heart is not a simple pumping device. It receives thousands of signals from other parts of the body," he said.

"For example, when a good-looking blonde walks down the street, your heart speeds up. To make mechanical hearts respond to a blonde will not be so easy. It's better to leave the heart in place to respond to all these signals and make a mechanical pump as an auxiliary device to do most of the work."

Doctor DeBakey is working toward development of a device that would allow the heart to rest long enough for it to recover its strength and resume its role in the body without assistance. Doctor Kantrowitz is working toward development of an implantable auxiliary device that would permanently aid those whose hearts cannot function adequately alone. Both these approaches and others similiar to them are of the type the institutes want to support.

"We want to develop both a family of highly efficient short-term devices to tide people over acute heart attacks and also completely implantable heart-assist devices," a NIH spokesman said.

"Then, after this type of development is worked out and devices have been proven in clinical trials with a high degree of reliability and it looks like total heart replacement is feasible, we will push toward that goal."

Doctor Kantrowitz praised the partnership between physicians and engineers necessary in the artificial heart field but he said efforts must be made to ensure that leadership in the research must remain with the medical profession and not be given to engineers who do not fully understand the medical problems involved.

Obesity Major Health Problem

Obesity has become a major health problem in the United States and a special health hazard for three obesity-prone groups, according to the Public Health Service.

Quoting a new PHS source book for health professionals, "Obesity and Health," the Service said that the prevalence of obesity in this country is a source of growing medical concern because "fat people are more likely to develop certain diseases and to die at an earlier age than people of normal weight."

Prime candidates for the development of obesity and its attendant association with certain serious disorders and possible early death, according to the PHS, are:

(1) Children whose relatives are obese: In one study, 73 per cent of 1,000 obese patients had at least one obese parent.

(2) Heavily built persons who also have corpulent tendencies: Obese individuals usually have a heavier physique than their non-obese counterparts. Large-boned and thickly muscled persons, particularly adolescents, who fit this description should be watched closely.

(3) Persons who are becoming less active, more sedentary: Food intake does not decrease proportionately with decrease in energy expenditure. As activity decreases, for whatever reason, the risk of developing obesity increases.

The Service said that while a substantial amount of obesity exists at every age in both sexes, obesity in children and adolescents is a particularly discouraging omen for the future.

Children's Aspirin

No bottle of children's aspirin sold after July 1, 1967, will contain more than 36 tablets in a joint government-industry effort to reduce accidental overdose.

This restriction was one of several steps announced jointly by the Food and Drug Administration and 32 drug firms after a conference aimed at curbing childhood deaths and illnesses.

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Obituaries

JOHN DOVE LEE, M. D.

Dr. John D. Lee, 82, died at his home at Rock Creek in Raleigh County in November after suffering a heart attack.

Doctor Lee received his M. D. degree in 1912 from the Southern College of Medicine and Surgery in Atlanta, Georgia. He was a former member of the West Virginia State Medical Association.

He once served as company physician for the Raleigh-Wyoming Coal Company but later went into private practice.

Survivors include the widow, Mrs. Olive Lee; sons, James Lawrence and Daniel O. of Richmond, Virginia; and four grandchildren.

* * * *

EMORY EDWARD LOVAS, M. D.

Dr. Emory E. Lovas, 61, of Bluefield, died in a hospital in that city on November 13. He had been in declining health for several years.

A native of Glen Alum in Mingo County, Doctor Lovas attended Catholic University in Washington, D. C., and received his M. D. degree in 1928 from the Medical College of Virginia. He served his internship at Roanoke City Hospital in Virginia.

He was a member of the Mercer County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Doctor Lovas had been affiliated with United States Steel Corp. at Rock District Center in Gary for five and a half years. He had practiced medicine in Berwind, McDowell County for 31 years prior to that.

Survivors include the widow, Mrs. Helen T. Lovas; a daughter, Mrs. H. Howard West of Louisville, Kentucky; three sisters, Mrs. H. M. Leedy and Anna and Julia Lovas of Cheverly, Maryland; and one grandson.

* * * *

EARL B. GERLACH, M. D.

Dr. Earl B. Gerlach, who practiced medicine in Huntington for 45 years, died on December 6 in a hospital in West Palm Beach, Florida, where he had lived in retirement. He was 77.

A native of Crown City, Ohio, Doctor Gerlach received his M. D. degree in 1911 from the University of Cincinnati College of Medicine.

While in Huntington, Doctor Gerlach served as County Coroner of Cabell County and as City Health Officer for a period in the 1920s. When he retired in 1956, he was plant physician for the Huntington Alloy Products Division of International Nickel Company.

He was an honorary member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Julia J. Gerlach, and a stepson, George Clark of West Palm Beach.

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OBITUARIES—(Continued)

CURTIS GARLAND POWER, M. D.

Dr. Curtis G. Power of Martinsburg died in a Martinsburg Hospital on November 17 at the age of 63.

He was a brother of Mr. F. Ray Power of Charleston, former Director of the State Division of Vocational Rehabilitation.

A native of Levels, Hampshire County, Doctor Power attended Shepherd College and Marshall University before receiving his M. D. degree from the West Virginia University School of Medicine and the Medical College of Virginia in 1931.

Doctor Power was a member of the Eastern Panhandle Medical Society, of which he was a Past President; the West Virginia State Medical Association; and the American Medical Association. He also held membership in the West Virginia Chapter of the American Academy of General Practice; the American Geriatric Society; and the International Anesthesia Research Society.

Besides the brother, other survivors include: the widow, the former Frances Douglass Needy; one daughter, Mrs. Patricia Ellen Dickey of Roanoke, Virginia; one son, Dr. Curtis G. Power, Jr., of Portsmouth, Virginia; nine grandchildren; three other brothers, B. W. Power of Martinsburg, John T. Power of Martinsburg, and C. Boyd Power of Boynton Beach, Florida; and one sister, Mrs. W. R. Thacher of Shepherdstown.

County Societies

BARBOUR-RANDOLPH-TUCKER

Dr. Heinz Wittig, Professor of Pediatric Allergy at the West Virginia University School of Medicine, was guest speaker at a meeting of the Barbour-Randolph-Tucker County Medical Society which was held in Elkins on November 17.

Doctor Wittig presented an interesting paper on "Recent Progress in Immuno-globulins." He discussed the physiology and pathology involved in the immuno-globulins and the antibody reaction.

Twenty-six members and guests attended the meeting.—A. Kyle Bush, M. D., Secretary.

* * * *

McDOWELL

Dr. Stephen Mamick of Welch was elected President of the McDowell County Medical Society during the Society's regular monthly meeting, which was held in Welch on November 9.

Other new officers for the coming year are: Dr. Richard O. Gale of Welch, Vice President; Dr. Joseph C. Ray of Welch, Secretary; and Dr. J. R. Hatfield of Welch, Treasurer.

Dr. Roy R. Raub of Bluefield was guest speaker. He told about his safari in southern Africa.—John S. Cook, M. D., Secretary.

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MERCER

Dr. J. E. Blaydes of Bluefield was elected President of the Mercer County Medical Society during the organization's regular monthly meeting at the West Virginian Hotel in Bluefield on November 21.

Other officers elected for the coming year included: Dr. C. D. Pruett, Vice President; and Dr. John J. Mahood, Secretary-Treasurer.

Guest speaker was Dr. Alvin L. Watne, Associate Professor of Surgery at the WVU School of Medicine. Doctor Watne gave an interesting talk on Cancer Palliation. He illustrated his discussion with slides and demonstrated several cases of regional perfusion using nitrogen mustard and methotrexate.

The Society voted to make a donation to the Mercer County Heart Association in memory of Dr. E. E. Lovas, who died on November 13.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

Dr. T. S. Danowski of the University of Pittsburgh School of Medicine was guest speaker at the regular monthly meeting of the Monongalia County Medical Society on November 1.

Doctor Danowski's topic was "Office Care of the Diabetic."

During the business session, Dr. W. Gene Klingberg led a discussion of "Kiddiecare." He said there will be a program on March 30-31 on "Child Legislation and Health."

Forty-two members and guests attended the meeting.—Robert Greco, M. D., Secrtary.

* * * *

WYOMING

Dr. Manuel E. Tayko of Mullens was guest speaker at the fall meeting of the Wyoming County Medical Society, which was held at Wyoming General Hospital in Mullens on November 4.

Doctor Tayko discussed "The Management of Burns."

The Society voted to make a contribution to the United Fund, and a Committee on Medicine and Religion was appointed.—George F. Fordham, M. D., Secretary.

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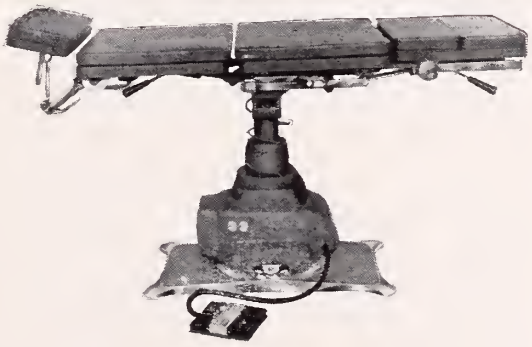

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KANAWHA

Dr. John T. Chambers was guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Kanawha Medical Society which was held on November 15.

Doctor Chambers' topic was "What Doctors' Wives Should Know about Medicare." He said the average elderly patient who seeks medical services is worse off now than he was before Medicare. He explained that most people over 65 who have maintained their own hospital and medical insurance now find that

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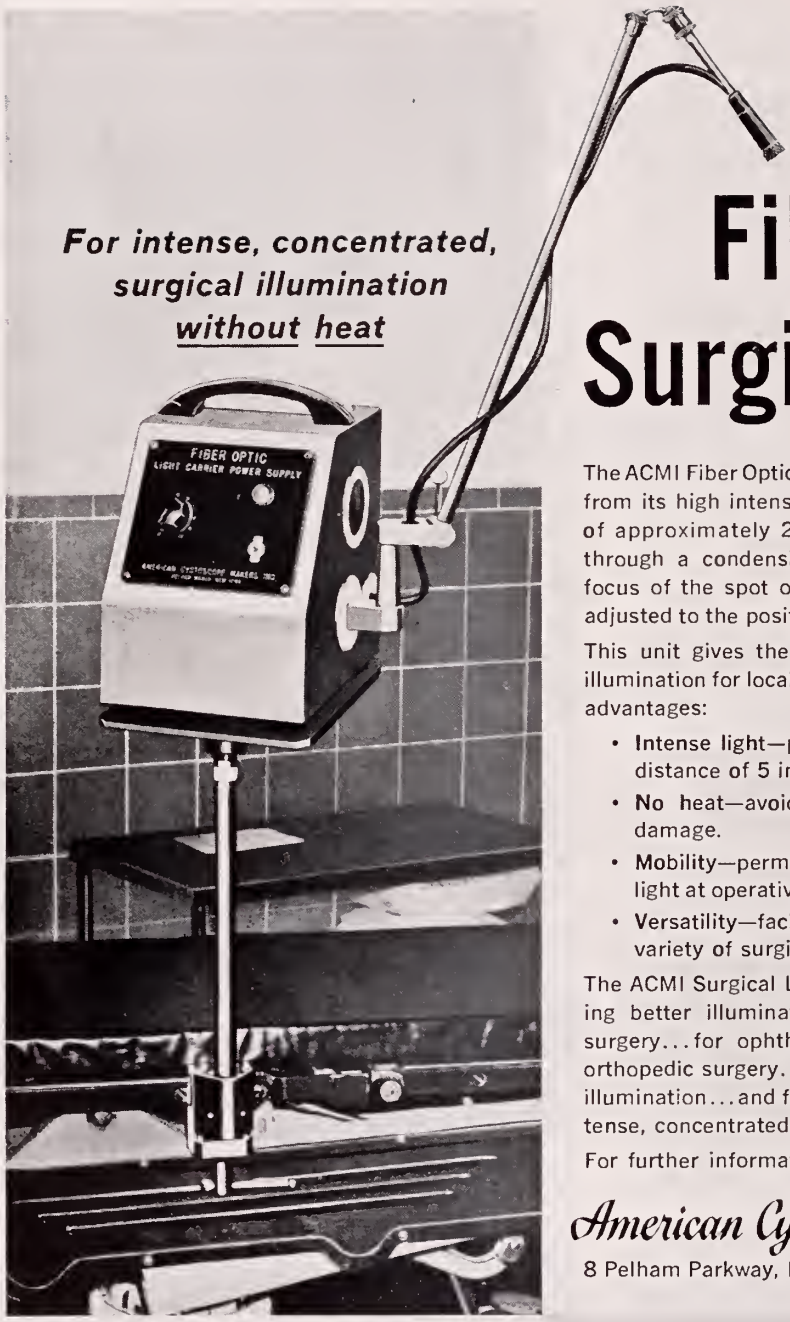

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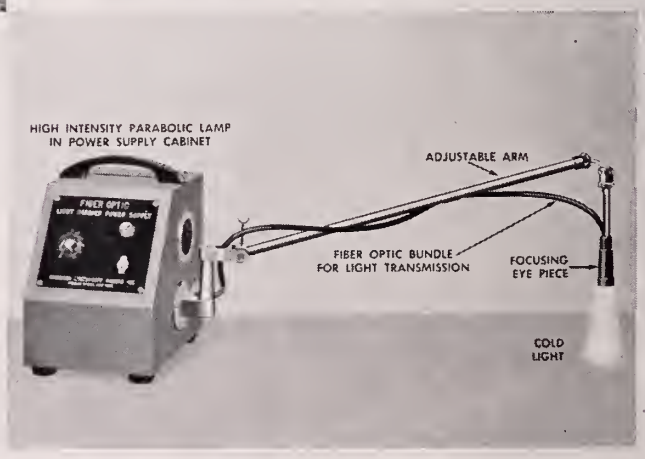

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their benefits have been cut back to cover only what Medicare does not cover.—Mrs. H. A. Jackson, Publicity Chairman.

* * * *

MARION

A coffee preceded the regular monthly meeting of the Woman's Auxiliary to the Marion County Medical Society which was held on November 29 at the home of Dr. and Mrs. John W. Kramer of Fairmont.

Co-hostesses were Mrs. G. Thomas Evans and Mrs. Robert Janes.

Proceeds from the sale of a ceramic figurine and baked goods will be donated to AMA-ERF.

* * * *

MERCER

Dr. Robert W. Neilson of Bluefield was guest speaker at the November meeting of the Woman's Auxiliary to the Mercer County Medical Society.

Doctor Neilson reported on his experiences as a physician in "Project Viet Nam" last Summer.

Seventeen members attended the meeting.

* * * *

MONONGALIA

The Woman's Auxiliary to the Monongalia County Medical Society held its regular monthly meeting in December at the Hotel Morgan in Morgantown.

Hostesses for the dinner meeting were Mesdames W. Gene Klingberg, Clement A. Smith, Carl E. Johnson, Edmund B. Flink, Ralph W. Ryan, W. Merle Warman and S. Charles Dotson, Jr.

A delightful program of Christmas carols was presented by a group known as the "Rondoliers", which is composed of West Virginia University students.

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Book Reviews

MEDICAL AND OTHER ESSAYS—By Edward J. Van Liere, Ph. D., M. D., Dean Emeritus and Professor of Physiology, West Virginia University School of Medicine. McClain Printing Company, Parsons, West Virginia. 1966. Pp. 166. Price $5.00.

The Dean, in "a tribute to his former students," has taken his ex-students and friends for a delightful tour through many phases of medical physiology, philosophy and "who done its."

We are glad to read and reread those editorials and essays that have appeared in *The Journal* over the past years. In the varied and multiple categories in which he excels—medical essays, medical education, biography and a wide-spread miscellany—Doctor Van Liere has provided pleasant provender for all.

The essay on retirement is particularly recommended to those in the medicare age period and to all those people in public service, elective or appointive, who feel that they have a custodial right to continue their occupation into the chronological realms of senility.

In this Centennial year the short history of medical education in West Virginia is appropriate. For further information on this subject readers are referred to "Medical Education in West Virginia" by Van Liere and Dodds.

The last essay, recently published in *The Archives of Medicine* on the Subclavian Steal as applied to Dr. John H. Watson, is an excellent treatise on applied clinical medicine and especially interesting to the multitude of Sherlock Holmes' fans.—George F. Evans, M. D.

* * * *

ARTERIOGRAPHY—Principles and Techniques—By Joseph L. Curry, M. D., & Willard J. Howland, M. D., Department of Radiology, Ohio Valley General Hospital, Wheeling, W. Va. W. B. Saunders Company; Philadelphia, London. Pp. 328. Illustrated. Price $14.00.

This is an excellent commentary on the utilization of arteriography in community hospital practice written by two radiologists from West Virginia. The book outlines in good detail the problems associated with this rapidly growing field and re-emphasizes that it is necessary for one to have proper equipment and personnel in the Department of Radiology to perform the procedures, as well as adequate surgical personnel to handle corrective surgery and any complications.

This book is written primarily for those in practice in the small community hospitals. The authors cover essential equipment and materials utilized, the technique for performing the examinations, complications and precautions and practical, clinical considerations in the examinations. Arteriography of the extremity, cerebral vessels, aorta and selective arteriography of branches of the aorta are discussed.

The format of the book is excellent and the reproductions throughout are very good.

This book has interest for all practicing physicians who care for patients requiring arteriography as it would enable the physician to explain the procedure better to the patient knowing of the complications and the end results.—J. D. H. Wilson, M. D.

* * * *

OBSTETRICS AND GYNECOLOGY—By J. Robert Wilson, M. D., Professor of Obstetrics and Gynecology, University of Michigan Medical School; Clayton T. Beecham, M. D., Director of Gynecology and Obstetrics, The Geisenger Medical Center; Elsie Reid Carrington, M. D., Woman's Medical College of Pennsylvania. The C. V. Mosby Company, St. Louis. 1966. Pp. 775. Illustrated. Price: $15.50.

The authors of this third edition of a very fine textbook on obstetrics and gynecology have again done an outstanding job in incorporating into their book basic information on this discipline of medicine. Indeed, to cover the entire subject of obstetrics and gynecology in 776 pages would seem a monumental task.

To provide a background in obstetrics and gynecology which is essential for medical students and practicing physicians in every field has been the aim of the authors. They have laid the foundation for the emotional and physiologic phases of reproduction upon which the student can build by advanced study and practice.

Many sections of the older edition have been extensively revised and expanded. The material on psychology and psychosexual problems has been enlarged to include the emotional as well as the physical growth of women. A new chapter concerning conception control has been added and the one on trophoblastic disease has been almost rewritten entirely. The section on pediatric gynecology again is remarkable. Throughout the text an intermingling of obstetrics and gynecology is noted instead of being divided into separate sections.

The book is easily readable, concise and is well supplied with pictures, charts, tables and diagrams. There are 346 illustrations. It would seem ideal for medical students and anyone wishing to consult or review subjects pertaining to obstetrics and gynecology.—Thomas R. Poole, M. D.

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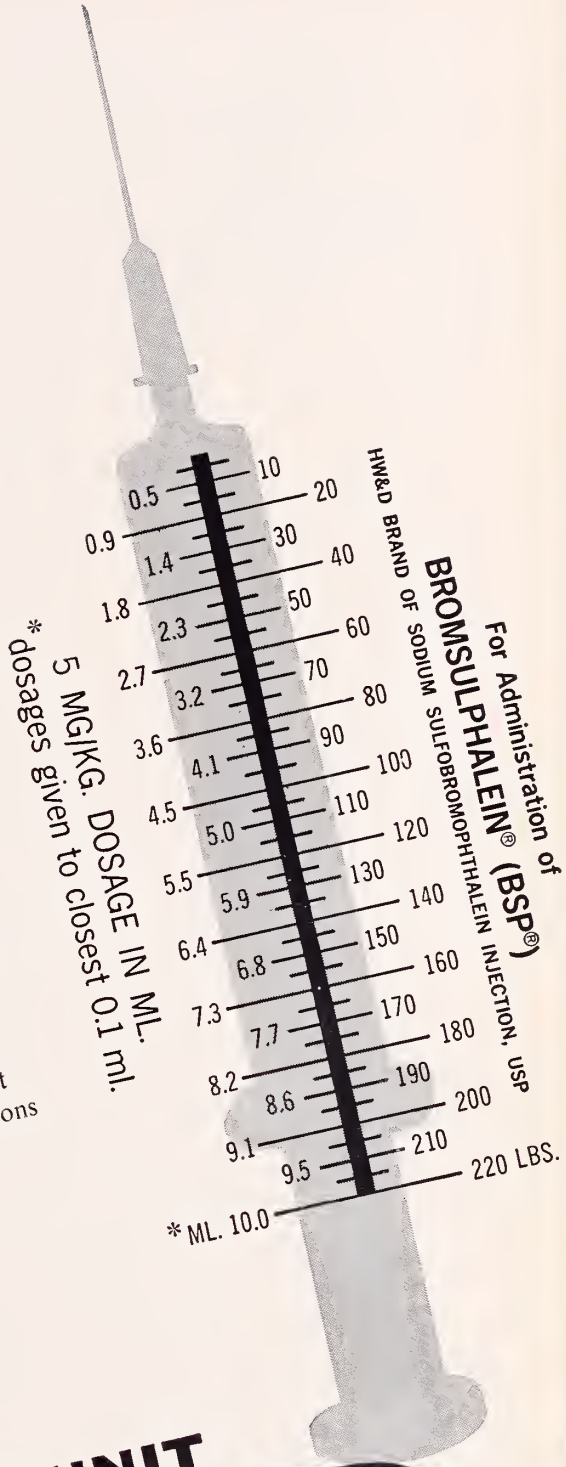

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50c per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

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The West Virginia Medical Journal

Vol. 63, No. 2 February, 1967

Digitalis Intoxication*

James W. Woodford, M. D., and Robert J. Marshall, M. D., M. R. C. P.

Withering[1] was as aware of the toxic effects of digitalis as he was of its therapeutic efficacy. He warned, in 1785, that ". . the Foxgrove, when given in very and quickly repeated doses, occasions sickness, vomiting, purging, giddiness, confused vision, objects appearing green or yellow; increased secretion of urine, with frequent motion to part with it; slow pulse, even as slow as 35 in a minute, cold sweats, convulsions, syncope, death. I am doubtful whether it does not sometimes excite a copious flow of saliva."

It has been reported that one of every five patients receiving digitalis in general hospitals has some degree of toxicity. The reported incidence may be higher than that among the population at large, since hospitals contain a disproportionately high population of the more seriously ill and elderly patients with cardiac disease.[2] Nonetheless, the incidence of digitalis toxicity in most reports ranges at least between 7 and 15 per cent. The possibility of toxicity, therefore, should be anticipated in every patient taking digitalis.[3]

Genesis of Intoxication

There are several reasons for the frequency of intoxication.

(1) The margin of therapeutic safety is narrow.[4,5]

(2) Individuals even of comparable size may vary considerably in their requirement of digitalis. Thus, 0.25 mg. digoxin may be an excessive daily dose for some, while 0.5 mg. may be inadequate for others. Attempts to conform to a rigid schedule of dosage may result in the intoxication of some patients and inadequate treatment of others. Dosage must be tailored to the individual, initially often on a cautious "trial and error" basis.

(3) Formerly crude preparations such as digitalis leaf were used almost exclusively. They caused gastro-intestinal symptoms when used in excessive doses. These symptoms provide a warning to reduce the dosage and thereby to avoid the occurrence of more serious toxic effects. They have now been largely replaced by pure alkaloids such as digoxin. These often do not produce symptoms of gastro-intestinal irritation, so that a dangerous arrhythmia may be the first clue that intoxication has occurred.

(4) There are more aged patients today than ever before. In such cases renal, hepatic, or pulmonary insufficiency may increase susceptibility to digitalis intoxication. Since 60 to 80 per cent of the digitalis glycosides are excreted by the kidneys, renal failure may lead to a relative overdosage. The liver also is concerned with the degradation of digitalis into its active and inactive metabolites. Liver disease, therefore, may impair detoxication. Also, it has been shown that the occurrence of digitalis intoxication in patients with chronic pulmonary disease is related to the degree of peripheral arterial desaturation.[6]

(5) The effects of digitalis are influenced by the body's potassium balance. In hypokalemic states, relatively small doses of digitalis

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*Supported by a Student Research Grant to James W. Woodford by the West Virginia Heart Association.

Submitted to the Publication Committee, June 10, 1966.

may lead to intoxication. Conversely, in hyperkalemia much larger doses of digitalis may be given, and the patient appears to be "protected." Patients with conditions which tend to produce hypokalemia should then be even more closely observed for toxic effects in those receiving digitalis. Diuretic drugs, when used frequently and persistently, and especially when used for a period longer than three weeks, may lead to excessive loss of potassium unless care is taken to replace this ion. Mercurial compounds and acetazolamide (Diamox) may be responsible, but drugs of the thiazide group cause more severe potassium loss than either of these, since they act both on the proximal and distal renal tubules.[7] Other potassium—losing states include diarrhea, adrenocorticoid therapy (or hypersecretion), familial periodic paralysis, and wasting diseases of muscles.

(6) Alterations in thyroid function may influence the plasma level of digitalis. Hyperthyroid patients have lower serum levels of digitalis, and hypothyroid patients higher levels than euthyroid patients on identical doses.[8] A dose which is therapeutic in a patient with Graves' disease well may be toxic in a patient with myxedema.

(7) Finally, to some extent, the increase in the incidence of digitalis intoxication may be more apparent than real, since there is at present greater awareness of the problem among physicians than there was in the past.

Signs and Symptoms of Intoxication

(1) *Gastro-intestinal System.* The earliest and most common symptoms of digitalis excess are anorexia, nausea and vomiting, usually in that order. Diarrhea is less common. Salivation often accompanies the nausea and, as Withering noted, it may be copious. Epigastric pain and nausea occurring early in the course of treatment with digitalis probably are side-effects, caused by gastric irritation. When these symptoms occur later in the course of treatment, they result mainly from the systemic action of digitalis, and particularly from its excitation of the chemoreceptor trigger zone in the medulla oblongata.[9] It also should be pointed out that anorexia, nausea and vomiting frequently are present in patients with congestive heart failure, and that as the failure responds to treatment with digitalis, these symptoms are likely to remit. Common sense, therefore, must be used in interpreting the significance of these symptoms.

(2) *Nervous System.* Neurological features have been found to be present in approximately 40 per cent of cases of digitalis intoxication; in frequency, they are second only to the gastrointestinal manifestations.[10] The commonest symptoms are blurred vision, the presence of flickering objects before the eyes, and illusions of color. Most commonly, objects appear yellow or green but any color may be noted. These changes originate in the brain rather than in the retina or optic nerve. Total but reversible blindness secondary to bilateral toxic retrobulbar neuritis also has been reported.[6] Other neuropsychiatric manifestations include dizziness, syncope, paresthesiae around the lips and hands, trigeminal neuralgia and toxic psychosis.

(3) *Less Common Side-Effects.* These include skin rashes, gynecomastia and increased blood coagulability.

Arrhythmias

Almost every type of arrhythmia may result from overtreatment or from intoxication with digitalis. The most common is bigeminy due to the occurrence of ventricular premature contractions, either unifocal or multifocal. The next three most common are the Wenckebach phenomenon, atrioventricular dissocation and nodal rhythm in decreasing frequency. These four arrhythmias accounted for 78 per cent of all the quasispecific electrocardiographic abnormalities noted in the series of 184 cases of digitalis intoxication observed during a five-year period at the Mayo Clinic.[10]

(1) *Atrial Arrhythmias.* — Paroxysmal atrial tachycardia, with various degrees of atrioventricular block, is relatively frequent and potentially serious (Figure 1). When the ventricular response is rapid and irregular, it may be mistaken for uncontrolled atrial fibrillation unless an electrocardiogram is taken and carefully examined. If the incorrect diagnosis is made, the patient may be given further doses of digitalis, sometimes with fatal consequences. Atrial flutter and atrial fibrillation may also on occasion result from digitalis intoxication.

(2) *Atrioventricular Nodal Arrhythmias.* — Besides nodal rhythm, nodal premature beats and nodal tachycardia commonly are seen. Again, one is dependent for their recognition on the characteristic changes in the timing and orientation of the P waves in relation to the QRS complexes.

(3) *Ventricular Arrhythmias.* — Ventricular bigeminy (or trigeminy) (Figure 2) may be the sole manifestation of intoxication or may precede, follow, or accompany other electrocardiographic signs of intoxication. The arrhythmias may progress to short runs of ventricular tachycardia, to persistent ventricular tachycardia, to alternating bidirectional tachycardia, or to ventricular fibrillation. Bidirectional tachycardia in particular has been considered to be "pre-fibrillatory."[11]

These arrhythmias, however, are not pathognomonic of digitalis intoxication. For example, ventricular bigeminy often occurs in patients with myocardial disease, particularly ischemic disease, in the complete absence of digitalis. In such cases, it often is abolished by the administration of digitalis in therapeutic doses.

Heart block may occur and may be either of first, second, or third degree. The Wenckebach variety is particularly characteristic.[10] In third degree block due to digitalis, the idioventricular rate usually is much higher (60 to 100 beats per minute) than it is in third degree block occurring in the course of various diseases (30 to 40 beats per minute).

Digitalis Effects

Digitalis commonly produces ST segment depressions characterized by upward concavity or "scooping," or by an oblique line descending from the ST junction (Figure 3). The T wave may be "dragged" downward simulating true T wave inversion. It must be emphasized that these changes occur in greater or lesser degree in most patients who are adequately digitalized. In other words, this represents digitalis effect but not toxicity.

Prevention and Treatment

Digitalis toxicity is easier to prevent than to treat, particularly since the effects of digitalis are cumulative. Before digitalizing a patient, the physician should keep in mind the following:

(1) Know what to expect from digitalis.

(2) Be thoroughly familiar with the use of one or, at most, two preparations rather than be only superficially acquainted with many.

(3) Never give digitalis parenterally when its use by mouth will suffice.

(4) During digitalization, start with the largest dose first.[6]

(5) If a patient has had one of the crude digitalis preparations within the last two to three weeks, do not give a full digitalizing dose. This does not hold true, however, for the "pure alkaloids" because of their more rapid degradation rates.

(6) Always obtain and analyze an electrocardiogram before treatment.

(7) Use supplemental potassium if mercurial or thiazide diuretics are given at the same time, or alternatively consider using a diuretic drug, such as spironolactone, that does not deplete body stores of potassium.

In the event that a patient does become intoxicated, digitalis should be withheld, at least temporarily, and other, more vigorous measures

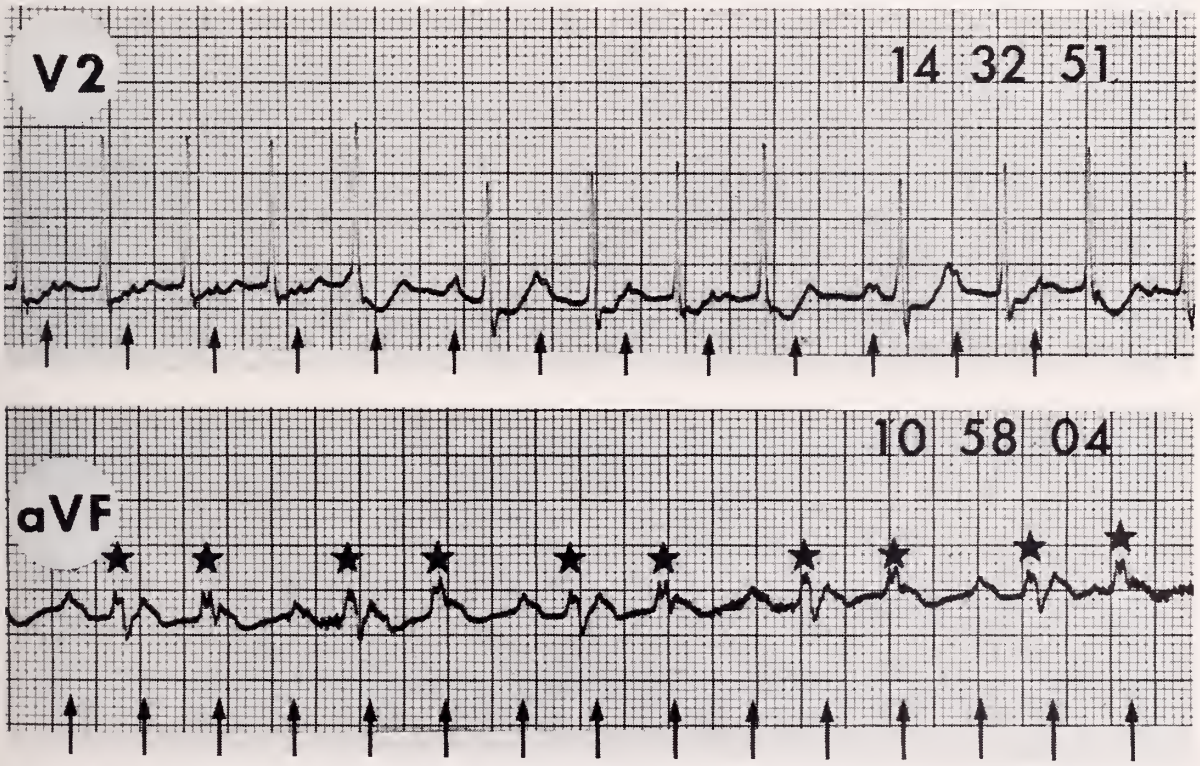

Figure 1. Paroxysmal atrial tachycardia with A-V block due to digitalis. Above: Irregular ventricular response. Arrows indicate P waves, which are occurring at the rate of 160 per minute. Below: A-V block of Wenckebach variety with 3:2 ventricular response. Arrows indicate P waves (rate 175 per minute) and asterisks indicate QRS complexes (rate 117 per minute).

should be employed depending on the severity of the case.

For mild symptoms. – Besides withdrawing digitalis for several days, potassium salts may be given by mouth in doses of 1 Gm. three times daily. An exception to this is digitalis-induced atrioventricular block (but not paroxysmal atrial tachycardia with block) in which potassium may potentiate the effects of digitalis on the conduction system, thereby further impairing conduction.[12]

For more urgent situations.–(a) Potassium. 40 mEq. should be given in 500 ml. of 5 per cent glucose solution intravenously over 1 to 2 hours under electrocardiographic control. Alternatively, 5 Gm. KCl may be given by mouth initially, followed by 2 Gm. every 3 to 4 hours. One should be particularly careful to avoid hyperkalemia.

(b) Procaine amide. 500 mg. intramuscularly may be given every 2 to 3 hours, or 100 mg. intravenously may be given every 1 to 2 minutes until the arrhythmia converts. The total dose should not exceed 1 to 2 Gm. Procaine amide should be used only for ventricular arrhythmias, and the blood pressure should be checked frequently during its administration.

(c) Diphenylhydantoin (Dilantin). The exact means by which Dilantin corrects cardiac arrhythmias has not been elucidated; it reduces the concentration of intracellular sodium, however, and it is inferred that the intracellular content of potassium is increased reciprocally. Also, it has been proven to act directly on the myocardium and not reflexly via the central venous system.[13]

Fifty milligrams of the original solution may be given intravenously per minute until the arrhythmia is converted or until the maximal dose of 500 mg. is reached. One should monitor with an electrocardiogram and check the blood pressure frequently since hypotension may be a side-effect. It has been found that there are few side-effects if the Dilantin is given at a rate no faster than 50 mg. per minute. If the arrhythmia is converted, then 100 mg. can be given by mouth three times daily for a sustained effect.

(d) Propranolol (Inderal). This is a specific beta-adrenergic blocking agent that has been shown to be a safe and effective drug in the treatment of digitalis-induced arrhythmias both of ventricular[14] and supraventricular[15] origin. The usual dose is 100 mg. per kg. body weight given intravenously over a 10-minute period with electrocardiographic monitoring. The maximal intravenous dose should be no more than 10 mg. This is a new drug, and it has not yet been released for general use in the United States.

(e) Chelation therapy. The value of this is debatable, the results often are erratic, the effects are of short duration, and there is possibility of

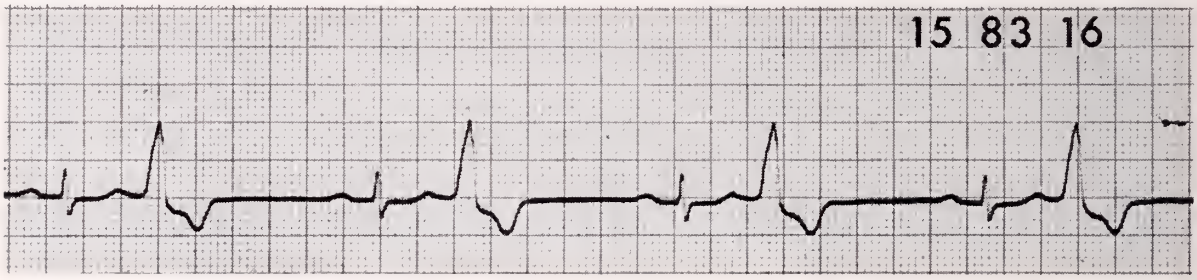

Figure 2. Ventricular bigeminy induced by digitalis. First degree block also is present (PR interval 0.23 second).

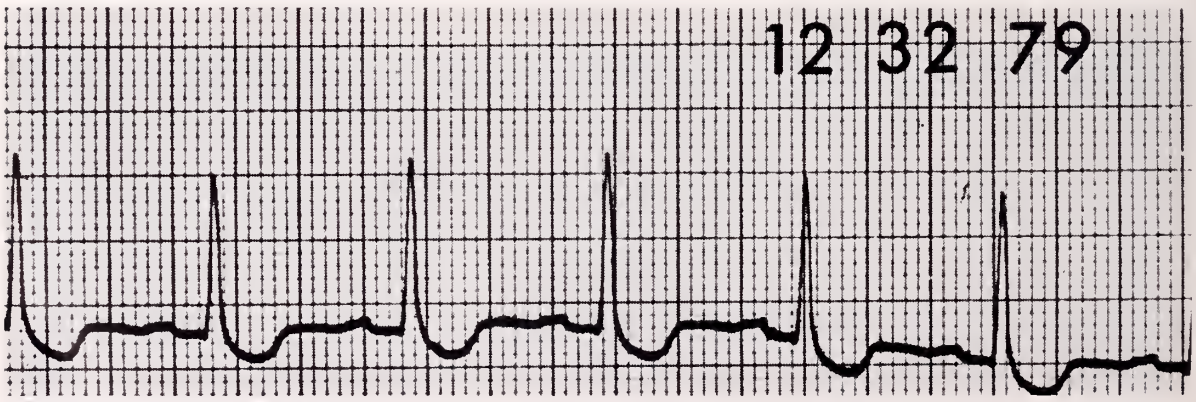

Figure 3. "Scooping" (upward concavity) of the ST segments in a patient receiving therapeutic doses of digitalis. This is not a manifestation of intoxication.

renal damage. Nonetheless, if decision is made to use it, 600 mg. EDTA (disodium versenate) are dissolved in 250 ml. of 5 per cent glucose solution and given intravenously over a period of 30 to 60 minutes. As much as 3.0 Gm. may be given. One should monitor frequently with the electrocardiogram.[12, 16]

(f) Electric countershock. This procedure is not indicated in digitalis-induced arrhythmias, since even if the normal rhythm is restored, the toxic state that originally predisposed to the arrhythmia still will be present.[16]

References

1. Withering, William, An Account of the Foxglove, Birmingham, England, Broomsleigh, 1785.
2. McIntosh, H. D., & Morris, J. J.: Problems in the Use of Digitalis in the Management of Congestive Heart Failure, Prog. Cardiovasc. Dis. 7:360, 1965.
3. Sodeman, W.: Current Concepts: Diagnosis and Treatment of Digitalis Toxicity, New England J. Med. 273:35, 1965.
4. Lown, B. & Levine, S.: Current Concepts in Digitalis Therapy, Boston, Little, Brown, 1954.
5. Selyer, A.: Editorial: Clinical Use of Digitalis: Science or Empiricism?, Circulation 28:1031, 1963.
6. Rosenberg, M. & Graettinger, J.: Digitalis Intoxication Management and Prevention, D. M., (Nov.) 1962.
7. Sampson, J.: Relation of Potassium to Digitalis Effectiveness and Toxicity, Calif. Med. 98:249, 1963.
8. Doberty, J. & Perkins, W.: Digoxin Metabolism in Hypo- and Hyperthyroidism, Ann. Int. Med. 64:-489, 1966.
9. Goodman, L. & Gilman, A.: Pharmacological Basis of Therapeutics, New York, Macmillan, 1965.
10. Dubnow, M. & Burchell, H.: A Comparison of Digitalis Intoxication in Two Separate Periods, Ann. Int. Med. 62:956, 1965.
11. Enselberg, C., Croce, J., & Lown, B.: Ventricular Fibrillation Due to Digitalis Preparations, Circulation 3:647, 1951.
12. Packman, R. & Utiger, R. (eds.), Manual of Medical Therapeutics, Boston, Little, Brown, 1964.
13. Lang, T. W., Bernstein, H., Barbieri, F., Gold, H. & Corday, E.: Digitalis Toxicity. Treatment with Diphenylhydantoin, Arch. Int. Med. 116:573, 1965.
14. Rowlands, D. J., Howitt, G., & Markman, P.: Propranolol (Inderal) in Disturbances of Cardiac Rhythms. Brit. M. J., i, 891, 1965.
15. Harrison, D., Griffin, J., & Fiene, T.: Effects of Beta-Adrenergic Blockade with Propranolol in Patients with Atrial Arrhythmias, New England J. Med. 273:410, 1965.
16. Bellet, S.: Clinical Disorders of the Heart Beat, Philadelphia, Lea and Febiger, 1963.

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Incidence of Strongyloides Stercoralis: A Survey of 200 Routine Admissions to the Veterans Administration Hospital in Beckley, West Virginia

Clifford D. Reiber, M. D., and Joseph E. McCoy, B. S., M. T. (ASCP)

INFECTION by Strongyloides *stercoralis* is not rare in the southern United States. Few surveys, however, have been made of significant segments of the population of this region, and reports on the subject thus far examined have dealt with relatively select groups. The incidence as reported by several observers has ranged from 0.35 per cent among 537 individuals on the relief rolls in Athens, Georgia,[1] to 6 per cent among patients appearing at the New Orleans Charity and Welfare Clinics.[2] Hinsman[3] found a 4.8 per cent incidence of the infection among 2,500 inmates of a Louisiana State Institution. Fecal examination in the cases of 1,244 patients admitted for all causes to one hospital in Floyd County, Kentucky, yielded an incidence of 5 per cent. Review of hospital records revealed the effects of Strongyloides infection were considered clinically significant in one case.[4]

It would appear that somewhat dissimilar socio-economic groups from different environmental situations have been used in these studies. Whether the results of such samplings are representative of the general population of these geographic areas may be questionable.

There seems to be a paucity of specific information about the distribution of Strongyloides *stercoralis,* not only in the region already referred to, but in other parts of the United States. Scattered cases have been reported from a few northern states but, of these, several concerned immigrants,[5] or individuals having resided previously in the tropics.[6, 7, 8]

The purpose of this paper is to record the incidence of Strongyloides *stercoralis* among 200 consecutive, routine admissions to a medium-sized Veterans Administration Hospital. Although the number of cases is not large, and a certain degree of selectivity unavoidable, it is felt that the data presented may be of value in helping complete the epidemiologic picture of a medically important parasite. The findings should not necessarily be interpreted as reflecting the actual rate of infection in this section of West Virginia.

Submitted to the Publication Committee, July 28, 1966.

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Methods of Study

During the period from May 14 to July 14, 1961, stool specimens from 200 patients admitted to the Beckley Veterans Administration Hospital were examined for rhabditiform larvae of Strongyloides *stercoralis.* A period of hospitalization of sufficient duration to allow at least three consecutive daily stool collections was the only criterion in selection of cases.

Direct microscopic examination of two wet-mount slide preparations from each specimen was performed, and in every case material was picked from a different portion of the specimen. An emulsion of the material with 1 per cent eosin in isotonic saline was placed on ordinary glass slides, and the entire area beneath a 22 sq. mm. cover-slip was subjected to a careful, systematic search. A binocular microscope equipped with 16 mm. objective and 10X oculars was employed.

Using ether-formalin technique,[9] a concentrated preparation made from each specimen, in addition to the two direct wet-mount slides described above, was scanned in a similar manner.

From those patients whose initial stool specimen was negative for rhabditiform larvae, at least two more specimens were obtained on separate days. No further investigation was made of those which again proved negative. Stool collections were continued on initially larva-positive patients until a second positive was found. Fulfilling this latter requirement occasionally necessitated carrying out as many as five additional examinations.

The presence of rhabditiform larvae was the only developmental stage noted throughout the study. When circumstances permitted, up to

four larvae in each slide were checked for depth of buccal cavity to exclude hookworm.

Results

Of the 200 patients, 9 were found to be infected with Strongyloides *stercoralis*. Table 1 lists the total number of larvae, both dead and alive, found in the two direct smears and the concentrated smear of the initial positive specimen from each case. Length of interval between collection and examination of any given specimen varied from one patient to the next. The larval count noted in the second positive stool specimen is not indicated since its function primarily was that of confirmation.

TABLE I

Case No.	Direct Smear No. 1	Direct Smear No. 2	Concentrated Smear
1	6	2	19
2	4	0	28
3	0	0	1
4	0	0	3
5	7	0	3
6	2	0	0
7	1	1	2
8	1	0	5
9	5	0	0

The number of positive cases is not sufficient for statistical analysis. Some results actually appear conflicting, as illustrated by the generally poor correlation between counts of larvae in direct smear No. 1 and direct smear No. 2. This observation, in spite of its apparent discrepancy, tends to reaffirm the opinion of most parasitologists that study of multiple portions of a given stool specimen are more likely to yield valid estimates of infection.

As might be anticipated, the concentrated smears showed a greater percentage of positives, and in some specimens the number of larvae per smear was notably greater. Here again, however, there was no consistent correlation. Results such as these have created a degree of skepticism in our minds as to the reliability of methods of stool examination generally recommended for routine use.

Duodenal aspiration has been advocated as a method of increased efficiency in identifying Strongyloides *stercoralis* infected cases. Jones,[10] in a survey of 100 veterans known previously to have been infected with Strongyloides *stercoralis*, found on re-examination both with concentrated and unconcentrated preparations only 27.4 per cent to have positive stools. In 20 cases in this series, the patients at no time showed the presence of larvae on 5 or more occasions. In 9 of the 20 cases, however, larvae could be demonstrated in aspirated duodenal contents. Jones reported also that duodenal aspirates were positive for Strongyloides *stercoralis* in 91 per cent of 71 cases. Interestingly enough, there were 6 patients in whose cases larvae were noted in the stools but not in the duodenal aspirate.

The experience of other observers with duodenal intubation has been less spectacular.

Of 67 individuals studied by Coutinho,[11] stool examinations in 38 were positive for Strongyloides *stercoralis* while the duodenal aspirate yielded positive results in only 24. In 14 of the 67, the larvae were found in the feces, but were absent in duodenal juice. In no instances were positive smears obtained by duodenal intubation when the stools were negative. Whether the addition of a technically more involved and complicated procedure to the routine of stool examination would be warranted seems unsettled in light of these results. Certainly there is need for further improvement and refinement of diagnostic techniques in this regard and need for additional investigation of this problem is indicated.

Tabulation of Related Clinical Data

It was considered worthwhile also to record data related both to the epidemiologic and clinicopathologic aspects of the disease. Attempts were made to obtain information regarding (1) geographic origin, occupation, and habitation of parasitized patients, (2) symptoms and complaints existing at the time of hospital entry and (3) evidence of eosinophilia.

Discussion

Geographic Origin.—To the present, the resident locale of each of the 9 persons with positive stools were determined insofar as possible by direct questioning or from available military records (Table 2). All were natives of continental United States. Only one individual (Case 5) claimed to have spent his entire life in the Southern Appalachian region. Four patients (Cases 3, 4, 7 & 8) denied having been outside the continental United States (Alaska excluded). Of the 3 veterans who lived for any period in areas other than continental United States, only one (Case 6) had been in a tropical country.

Because of the chronic nature of Strongyloides *stercoralis* infection, no definite conclusions may be drawn as to the exact area from which each of the patients acquired his original infection. Since a significant proportion of the population of southern West Virginia tends to remain in relatively restricted geographic sections for extended periods of time. However, it may be expected that this would directly affect the distribution of infected cases as well as the rate of infection. When interpreted from this stand-

point the data seem to indicate that in the majority, if not all, of the 9 cases, the initial Strongyloides *stercoralis* parasitism occurred in the southern Appalachian region.

Symptoms and Complaints.—It seems significant that in all but two of the 9 cases, there was a history of some form of gastrointestinal disturbance. Brief descriptions of the disturbances are listed (Table 2), with no consistent pattern apparent. Abdominal cramping was the most frequent complaint. Three patients were admitted to the hospital primarily for complaints referable to the gastrointestinal tract. It was possible to relate Strongyloides *stercoralis* infection directly to the clinical disease process in one of the three, with an admitting diagnosis of "ulcerative colitis". The two remaining patients were not provided with a specific diagnosis on entry. Of the latter, one presented definite gastrointestinal pathology in the form of a duodenal ulcer, while changes in the colon were less well defined, being designated simply as "spastic colon". No positive evidence of gastrointestinal disease was found in the third patient to explain the clinical disturbance other than larvae of Strongyloides *stercoralis* in the stool.

A carefully outlined program of observation after institution of antihelminthic therapy was not followed in every instance. It, therefore, is not possible to categorically state that the symptoms of these patients either were or were not entirely due to Strongyloides infection. There is good reason to feel that the infection played some part in the symptomatology and was the sole cause of complaints in at least one case. In many individuals the infection may be so mild as to remain unnoticed. There are, however, indications that in a high percentage of cases a variety of gastrointestinal symptoms is experienced.[14, 17] Very often these symptoms are intermittent and chronic in character, sometimes lasting for many months.[15] Because of the vagueness and intermittent nature of the complaints such patients may risk being labeled as psychoneurotic.

Not Innocuous Condition

The idea that Strongyloides *stercoralis* parasitism can be dismissed as a relatively innocent and innocuous condition is not supported by reports of a number of observers. Hartz,[12] and Brown and Perna[13] have cited instances of strongyloidiasis with fatal termination. Alcorn and Kotcher[16] describe two cases of malabsorption syndrome produced by chronic strongyloidiasis. It would seem that these various aspects of Strongyloides *stercoralis* infection demand more careful consideration in the diagnostic valuation of suspected gastrointestinal disease with ill defined or vague features, and particularly when it involves a patient from a known endemic area.

Eosinophilia.—Helminth infection is a recognized cause of eosinophilia and is seen with regularity in some types, especially at certain developmental stages. Such instances often do not present a diagnostic problem. Occasional patients, however, are encountered with persistent eosinophilia for which there is no readily

TABLE 2

CASE	DIAGNOSIS ON ADMISSION	DIAGNOSIS ON DISCHARGE	GASTROINTESTINAL SYMPTOMS & FINDINGS	PER CENT EOSINOPHILS	RESIDENCES OUTSIDE WEST VIRGINIA	PRESENT OCCUPATION	INTERVAL SINCE LAST OUT OF STATE
1	Hematuria	Hematuria, right kidney	Constipation Much Flatulence	19	N. Carolina, Virginia, France (military)	Railroader (Retired)	5 Yrs.
2	Ulcerative Colitis	Strongyloidiasis Cellulitis	Diarrhea Constipation	33	Ohio, N. Carolina, Virginia, France	Auditor	3½ Yrs.
3	Subtotal Gastrectomy	Post-Gastrectomy Syndrome Secondary Anemia	Abdominal Cramping	7	Texas, Florida, Ohio	Mechanic	1 Yr.
4	Diabetes Mellitus	Diabetes Mellitus, Acute Bronchitis	Constipation	15	Indiana, Washington, D. C., S. Carolina	Laborer (Floor Finisher)	3 Yrs.
5	Laennec's Cirrhosis	Laennec's Cirrhosis	Abdominal Cramping	7	Virginia	Miner (Coal)	25-30 Yrs.
6	Chronic Glomerulonephritis	Chronic Glomerulonephritis	None	3	Guam, S. Carolina, N. Carolina, California, Ohio	Pressman (Press Operator)	4 Yrs.
7	Malnutrition	Arteriosclerotic Heart Disease, Malnutrition, Osteoarthritis	None	3	Massachusetts, Virginia	Truck Driver	44 Yrs.
8	Observation for "GI Disease"	Observation for "GI Disease"	Abdominal Cramps With Vomiting	6	Tennessee, Indiana, Washington, D. C., Texas, Alaska, New Mexico, Kentucky	Laborer (Construction Worker)	1 Wk.
9	Observation for GI Bleeding	Duodenal Ulcer Spastic Colon	Abdominal Cramping and Soreness	4	Kentucky, Massachusetts, Wales, England, France	Laborer (Type Not Specified)	4 Yrs.

demonstrable cause. Although one can only speculate as to the frequency of hidden helminthic disease, it seems reasonable to assume that in a certain percentage of cases of "idiopathic eosinophilia," a causal relation does exist. The difficulty with which the diagnosis of strongyloidiasis is established in certain situations provides some basis for this assumption.

The single highest eosinophil count obtained during hospitalization is shown for each of the infected patients (Table 2). The figures represent per cent of total leukocyte count. Six patients had an increase in eosinophils above the normal range. The elevation of eosinophils was considerable in 3 cases, reaching 33 per cent in one (Case 2). It is of interest that this latter individual was admitted with a tentative diagnosis of ulcerative colitis (not substantiated by later examinations including sigmoidoscopy and roentgenography). Penetration of the bowel mucosa by filariform larvae of Strongyloides *stercoralis* is known to produce local irritation which at times is severe.[3, 12] (Unfortunately, biopsy specimens were not taken in this case so that the degree of intestinal wall involvement, if any, is not known).

This rather superficial check for eosinophilia in a relatively small number of cases in which Strongyloides *stercoralis* infection was demonstrated, is not presented as proof of a causal relation. Other conditions which might be responsible for the blood picture have not been entirely ruled out. Yet, inconclusive as the evidence may appear, implication of strongyloidiasis as the basis for the eosinophilia cannot be ignored. The results further suggest that consideration should be given to the possibility of an occult Strongyloides *stercoralis* infection when one is confronted with the problem of "idiopathic eosinophilia."

Summary

Strongyloides *stercoralis* infection was found in 9 of 200 consecutive routine admissions to a medium sized Veterans Administration Hospital. Data concerning these individuals' geographic origin, nature of symptoms, complaints on admission, and eosinophil counts are recorded. In 7 cases, the infected patients presented with gastrointestinal symptomatology and in 6 of these they showed eosinophilia. Other findings suggest that the majority acquired the strongyloidiasis in the southern Appalachian region, and identify West Virginia as part of the endemic area.

References

1. Byrd, E. E.: On the Incidence of Intestinal Parasites in 537 Individuals on Relief Rolls in the City of Athens, Georgia, and Vicinity, Am. J. Trop. Med. 16:39-45, 1936.
2. Faust, E. C.: The Symptomatology, Diagnosis and Treatment of Strongyloides Infection, JAMA 98: 2276-2277 (June 25) 1932.
3. Hinsman, E. H.: Clinical Aspects of Strongyloides Stercoralis Infection, Gastroenterol. 5:24-34, 1938.
4. Atchley, F. O.: Clinical Note: Survey of Enteric Parasites in Population of Eastern Kentucky, J. Parasitol. 45:518, 1959.
5. Bodon, G. R.: A Case of Strongyloides Stercoralis Infection, J. Lab. & Clin. Med. 26:1608-1611, 1941.
6. Whitehill, R. & Miller, M. H.: Infestation of Genitourinary Tract by Strongyloides Stercoralis: Case Report. Bull. Johns Hopkins Hosp. 75:169-174 1944.
7. Kyle, L. H., McKay, D. G. & Sparling, H. S., Jr.: Strongyloidiasis, Ann. Int. Med. 29:1014-1042, 1948.
8. Levin, M. B.: Infestation With Strongyloides Stercoralis, J. Lab. & Clin. Med. 28:680-682, 1943.
9. Ritchie, L. S.: Formalin-Ether Technique for Cysts, Ova and Larvae, Bull. U. S. Army Medical Department 8:326, 1948.
10. Jones, C. A.: Clinical Studies in Human Strongyloidiasis, Gastroenterol. 16:743-756, 1950.
11. Coutinho, J. O.: Estudo Comparative Entre Strongyloides, Folia Clin. et Biol. 18:125-131, 1925.
12. Hartz, P. H.: Human Strongyloidiasis With Internal Autoinfection, Arch. Path. 41:601, 1946.
13. Brown, H. W. & Parna, V. P.: An Overwhelming Strongyloides Infection, JAMA 168:1648-1651 (Nov. 22) 1958.
14. Jones, C. A.: Clinical Studies in Human Strongyloidiasis, I. Semeiology, Am. J. Digest. Dis. 6:743-756, 1961.
15. Simpson, V. E.: Strongyloidiasis, JAMA 112:828-833 (March 4) 1939.
16. Alcorn, M. O. & Kotcher, E.: Secondary Malabsorption Syndrome Produced by Chronic Strongyloidiasis, South. M. J. 54:193-197 (Feb.) 1961.
17. Swartzwelder, J. C.: Intestinal Helminthiasis and Its Treatment, J. Louisiana M. Soc. 111:394-403, 1959.

TABLETS

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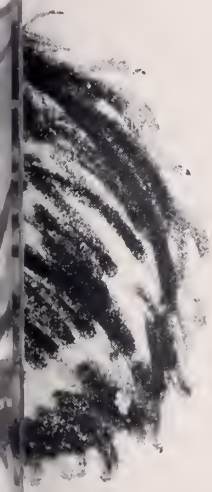

Primary Hyperparathyroidism*

(A Review of 20 Cases)

Herbert F. Schwarz, M. D.

THIRTY years have passed since Churchill and Cope[1] published the first series of successfully treated cases of primary hyperparathyroidism. The thorough clinical investigations of these patients by Albright, Aub and Bauer established the pathophysiology of this disease. In the ensuing years several hundred cases of hyperparathyroidism have been reported and many excellent treatises on the subject have been published.

Presented is a review of a series of 20 cases of primary hyperparathyroidism found during a six-and-one-half year period at the Beckley Memorial Hospital. This is a 193 bed hospital serving the beneficiaries of the United Mine Workers Welfare and Retirement Fund and includes an active outpatient department. A full time group of specialists and a resident staff administer the care of its patients.

Clinical Material

In 20 cases, a diagnosis of primary hyperparathyroidism was established at surgery or autopsy during the period from January 1958 through May 1964. There were 14 females and six males, a ratio of females to males of approximately 2:1, ranging in age from 35 to 72 years, with an average age of 57 years.

Clinical Syndromes

Urinary Calculi. — Calculous disease of the urinary tract is the most frequent complication of primary hyperparathyroidism and provides the clue to the diagnosis more often than all other complications or symptoms combined.[2,3] Melick and Henneman[4] showed that approximately 10 per cent of all patients with renal calculi had hyperparathyroidism. In our series of 20 cases, there were 14 (70 per cent) in which the patients had urinary tract calcinosis. In one case the patient had nephrocalcinosis while those in the remaining cases had urinary calculi. In 12 cases, the history or presence of stones provided the earliest clue to the diagnosis of hyperparathyroidism (Table 1).

Skeletal Disease.—The skeletal changes of classic osteitis fibrosa cystica are only rarely seen in this country today. A declining incidence of bone involvement has been reported in several larger series of cases of hyperparthyroidism[2,5] and has been attributed to earlier diagnosis of these cases and to the bone sparing effects of the relatively high calcium content of our diet.

In the classic case roetgenograms show erosion of the cortical surfaces of bones, demineralization of bones and localized destructive lesions.[5] Less advanced bone changes recognized now include subperiosteal resorption of bone, especially in the middle phalanges of the fingers, diffuse "miliary osteoporosis" of the skull, and partial or complete disapperance of the lamina dura of the teeth.[2]

In our series of cases, advanced skeletal changes were found in only one and, in this case, furnished the diagnostic clue. In four cases, mild to moderate skeletal changes were noted and felt to be consistent with hyperparathyroidism. In Case 5 destructive bone changes were associated with metastatic carcinoma of the bladder, and hyperparathyroid bone disease could not be proven. Excluding this case, skeletal involvement was present in five of 19 cases (26.3 per cent).

Thyroid Abnormalities.—There appears to be a rather high incidence of thyroid abnormalities in cases of primary hyperparathyroidism. Adams and Murphy[5] found thyroid disease in 46.9 per cent of 32 cases at the Lahey Clinic. Ellenberg and associates[6] reported carcinoma of the thyroid gland in 7.5 per cent of 93 cases of hyperparathyroidism. The hypercalcemia of hyperparathyroidism may be responsible for the thyroid changes since it was shown by Taylor[7] that calcium is a goitrogen. In our own series of 20 cases, there were nine (45 per cent) in which

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Submitted to the Publication Committee, August 18, 1966.

there were histologically proven thyroid abnormalities. In four cases (20 per cent), thyroid enlargement furnished the diagnostic clue. In none of our cases was there carcinoma of the thyroid gland and in all cases a euthyroid state existed (Table 1).

Peptic Ulcer and Pancreatitis.—There apparently is an impressive number of cases of hyperparathyroidism in which there has been peptic ulcer or recurrent acute pancreatitis. Keating[2] reported peptic ulcer in 59 of 380 cases (15.5 per cent) of hyperparathyroidism at the Mayo Clinic. Frame and Haubrich[8] found four cases of hyperparathyroidism in 300 consecutive cases of peptic ulcer, an incidence of 1.3 per cent. Spiro[9] found that hypercalcemia and hyperacidity of the stomach were related and showed that parathormone may increase gastric juice output. The patients in two of our cases (10 per cent) had duodenal ulcer (Table 1).

Of the reported cases of pancreatitis the majority had pancreatic calculi.[10,11] There were no cases of pancreatitis in our series.

Hypercalcemic Syndrome.—A diverse group of symptoms ascribed to hypercalcemia include nonspecific gastrointestinal complaints, fatigue, lassitude, backache, polydipsia, polyuria, anorexia and psychological manifestations. A diagnosis of hyperparathyroidism was made in two cases in which these symptoms were the only manifestations of the disease (Table 1).

Laboratory Diagnosis

Hypercalcemia.—Hypercalcemia is the *sine qua non* in the diagnosis of primary hyperparathyroidism. Every patient tested in our series had elevated serum calcium on three occasions, at least, and on only four occasions was the calcium less than 10.5 mg. per cent, in a total of 107 determinations run in the series. Since the total serum calcium includes a protein-bound fraction, adjustments must be made in hypoproteinemic patients. Cope[3] adds 1 mg. to the measured calcium level for each Gm. of protein below the average normal level of 6.5 Gm. per cent.

The degree of hypercalcemia at times may be minimal. It has been suggested that in these instances the disease poses very little threat to the patient. Keating[2] has shown, however, that complications of hyperparathyroidism already may be present in a significant number of cases with minimal chemical changes. In our series, there were two cases in which the patients, with borderline elevations, had renal calculi.

The highest values of serum calcium often are seen when skeletal disease is present. In the cases of four patients with mean calcium over 12.5 mg. per cent, bone disease was present in two.

Hypophosphatemia.—Hypophosphatemia was present in 14 or 73.7 per cent, of 19 cases in this series. As many as 60 per cent of cases, however, may have normal serum phosphorus

TABLE 1

Clinical Findings in 20 Cases of Primary Hyperparathyroidism

CASES	AGE	SEX	RACE	DIAGNOSTIC CLUE	URINARY CALCULI	BONE CHANGES	THYROID ABNORMALITIES	PEPTIC ULCER
1	57	F	N	Urinary Calculi	Yes	None	None	Duodenal Ulcer
2	52	M	N	Urinary Calculi	Yes	Moderate	Adenomatous Goiter	None
3	35	F	W	Urinary Calculi	Yes	None	None	None
4	58	F	W	Urinary Calculi	Yes	None	None	None
5	52	M	W	(No ante-mortem diagnosis)	Yes	Uncertain*	Colloid Goiter	None
6	66	F	W	Bone Changes	Nephrocalcinosis	Advanced	None	Duodenal Ulcer
7	45	F	W	Urinary Calculi	Yes	None	Follicular Adenoma	None
8	52	F	W	Thyroid Enlarged	No	None	Fetal Adenomas	None
9	72	M	N	Urinary Calculi	Yes	None	None	None
10	52	M	W	Urinary Calculi	Yes	None	None	None
11	47	F	W	Back Pain, Fatigue, Epigastric Pain	No	None	None	None
12	54	F	W	Urinary Calculi	Yes	Moderate	None	None
13	62	M	N	Urinary Calculi	Yes	Mild	None	None
14	55	F	W	Thyroid Abnormality	No	None	Adenomatous Goiter	None
15	62	F	W	Weakness, Leg Pain, Headaches	No	None	None	None
16	48	F	W	Urinary Calculi	Yes	None	Adenomatous Goiter	None
17	61	F	W	Urinary Calculi	Yes	None	Adenomatous Goiter	None
18	66	F	W	Thyroid Abnormality	No	None	Adenomatous Goiter	None
19	72	M	W	Urinary Calculi	Yes	None	None	None
20	67	F	N	Thyroid Abnormality	No	Moderate	Adenomatous Goiter	None

*Destructive changes in the spine and sternum were associated with metastatic transitional cell carcinoma of the bladder, and hyperparathyroid bone disease could not be ruled out.

levels.[12] Our lowest values were present with the higher degrees of hypercalcemia.

Hypercalciuria.—An elevated urinary calcium, with quantities over 200 mg. per 24 hours is present in the majority of cases of hyperparathyroidism. Seventeen of 18 patients (94.4 per cent), after two- to three-day low calcium diet, had at least one elevated 24-hour urine calcium. Hypercalciuria, however, may be found also in a high percentage of urinary stone formers who do not have hyperparathyroidism.[13]

Alkaline Phosphatase.—The serum alkaline phosphatase is an index of osteoblastic activity which is increased as a compensatory response to increased osteoclastic resorption of bone. It is elevated only if clinically significant bone disease is present. In our series of cases, there was only one in which the patient had a significant elevation of this enzyme and his skeletal involvement was mild. Our case with advanced bone disease had a borderline phosphatase. In general, this test has been found unreliable in its diagnostic value.[14]

Tubular Reabsorption of Phosphorus.—A measure of the Tubular Reabsorption of Phosphorus (TRP) was introduced in 1953 to help in establishing the diagnosis of hyperparathyroidism in borderline cases.[15] Whereas normally the renal tubules reabsorb 80 to 90 per cent of the phosphate filtered through the glomeruli, this percentage is reduced in hyperparathyroidism.[5] Unfortunately, many false positive and false negative results are reported.[16] In our series, six of 10 patients with normal renal function had a decrease in TRP.

Surgical Treatment

Exploration of the parathyroid glands is performed through a standard thyroidectomy incision. All four parathyroid glands should be sought. When an adenoma is present the remaining glands either are normal or, more often, hypoplastic. Ten per cent of the lower glands are found within thymic tissue located in the upper anterior mediastinum but usually can be approached through the primary incision. Occasionally, one finds an intrathyroid parathyroid gland. Statistically, the adenoma is found in the inferior glands in 84 per cent of cases, with an equal incidence on the two sides. If the adenoma cannot be located in the neck, a sternum-splitting incision is used for thorough mediastinal exploration. This is infrequently necessary and was required only once in the first 200 cases, reported by Black and Zimmer,[17] from the Mayo Clinic. In hyperplasia all four glands are enlarged and the indicated procedure is removal of three glands and partial excision of the fourth.

In our series, 18 patients came to exploration while in two cases the diagnosis was confirmed at autopsy. Exploration of the neck was the only procedure performed in this group. Partial thyroidectomy was done in the cases of seven patients with associated thyroid abnormalities and a total thyroidectomy was chosen in the case of one patient with a multinodular goiter.

Pathologic Findings

A single adenoma is the most frequent pathological finding in primary hyperparathyroidism. Hyperplasia of all four parathyroid glands occurs in approximately 12 per cent of cases in large series.[3] Multiple adenomas (usually two) and carcinoma of the parathyroid glands are relatively rare lesions. Castleman[18] has described the gross and microscopic findings of these lesions elsewhere.

In 18 of the present series of 20 cases, there is a histologic diagnosis. Of the 18, a single adenoma was found in 16 cases. Of the remaining two cases, there was one of double adenoma and one of hyperplasia. In general, the size of the adenomatous tissue correlated with the height of the serum calcium levels. When the mean serum calcium was 12.0 mg. per cent or higher, the lesion usually measured around 3.5 cm.

Results

Parathyroid adenomas were present in 15 surgical and two autopsy cases. In all operated cases, the blood chemistry has promptly returned to normal. These patients may be considered cured. In two cases, no abnormal parathyroid tissue was found. In the first of these (Case 14), total thyroidectomy was performed in the hope of finding an intrathyroid adenoma. In this case, an extensive search failed to produce any trace either of normal or abnormal parathyroid tissue in the neck. The patient has remained hypercalcemic. The total absence of any parathyroid tissue in the neck and the persistence of chemical abnormalities following surgery is practically diagnostic of a mediastinal adenoma. She is awaiting mediastinal exploration. In the other case (Case 16), traces of normal parathyroid tissue were encountered in three of the four usual locations and "snippets" of these were excised for frozen section. No abnormal tissue was identified by the pathologist. Her calciums returned to normal immediately following surgery, however, and were still normal at last follow-up, one year later. Other cases have been reported with similar "cures" in the absence of histologic abnormalities. Very likely the extensive dissection in these cases destroys the blood supply of "missed" lesions and cures the patient. In Case

3 hyperplasia was present but not recognized at the operating table. Only two glands were excised in the belief that this was a case of double adenoma and she has remained hypercalcemic and symptomatic. Therefore, of 18 cases of hyperparathyroidism treated surgically, there have been 16 cures.

In one case, hypoparathyroidism has developed since surgery and the patient is being maintained on oral calcium and Vitamin D. This case represents the only significant complication of surgical treatment.

Discussion

At the Beckley Memorial Hospital all patients with calculous disease of the urinary tract and all those with significant demineralizing disease of the bones are routinely screened for hyperparathyroidism. In addition, for the past few years as we have become more familiar with the disease, we have extended our screening to include patients with peptic ulcer, pancreatitis and nonspecific musculoskeletal and gastrointestinal complaints. Early during 1963, we have added patients with thyroid enlargement to the suspect list for hyperparathyroidism.

We believe that thyroid abnormalities as diagnostic clues have not been sufficiently emphasized in the literature. A review of the first eight cases in our series revealed thyroid pathology in 50 per cent. This finding plus the similar experiences at the Lahey Clinic[5] suggested that this group of patients might constitute a fruitful source for the discovery of new cases of hyperparathyroidism. Since beginning the routine screening of patients with thyroid enlargement, we have added three cases to the series in which none of the more conventional clues was present. We feel that the importance of this diagnostic clue may be second only to calculous disease of the urinary tract.

We have been disappointed by the lack of results in screening patients with peptic ulcer. Our clinic and hospital population has an exceptionally high incidence of duodenal ulcer. Although only a fraction of these have been studied, we have not uncovered any new cases of hyperparathyroidism.

In the routine investigation of patients with a diagnostic clue a serum calcium and phosphorus are obtained initially. When a calcium of 10.5 mg. per cent or above, or a phosphorus of less than 3.0 mg. per cent is reported, at least two additional determinations are ordered. Also obtained at this time are blood urea nitrogen or nonprotein nitrogen, total serum protein and serum alkaline phosphatase. If the repeat tests continue to be borderline or definitely abnormal, the patient is placed on a low calcium diet for three days following which 24-hour urine collections are obtained for calcium determinations. Meanwhile roentgenograms of the hands and skull, and a flat plate of the abdomen are obtained. Although many of our patients had a more extensive radiographic work-up, this is rarely necessary. Skeletal changes, when present, most often will be found in the phalanges and the skull. The abdominal plate will reveal most urinary and pancreatic calculi. In any patient with urinary calculi or demineralizing bone disease, or both, three elevated serum calciums and one elevated urine calcium usually are sufficient to warrant consideration of surgical exploration.

As an increasing number of patients are being screened throughout the country there has resulted a rapidly expanding list of conditions other than hyperparathyroidism that have been found often associated with hypercalcemia. Among these are hypervitaminosis D, Burnett's milk-alkali syndrome, multiple myeloma, sarcoidosis, hyperthyroidism and malignant diseases with or without bone involvement. In our hospital, we have been particularly impressed with the high incidence of hypercalcemia in malignancy, especially lung cancer. We agree with Gordon[12] that malignancy probably is the most common cause of hypercalcemia. In our group with thyroid abnormalities, we have been careful to rule out thyrotoxicosis. Toxic goiter may produce osteitis fibrosa cystica as well as hypercalcemia.

Often considerable difficulty is encountered in differentiating the hypercalcemic states. Hypophosphatemia may occur in nonparathyroid hypercalcemic disorders. Hypercalciuria is consistently absent only in the milk-alkali syndrome. Nephrocalcinosis may occur in multiple myeloma, Boeck's sarcoid and milk-alkali syndrome. The Cortisone Suppression Test[19] has been useful in difficult cases. Large doses of cortisone given for one week will suppress the hypercalcemia of most of the nonparathyroid states but not that of primary hyperparathyroidism. After all other conditions have been satisfactorily ruled out, the patient with persistent hypercalcemia and hypercalciuria should undergo parathyroid exploration.

We have not explored any patient with normal or borderline calciums even in the presence of persistent hypophosphatemia. Hyperparathyroidism is extremely rare with normal serum calciums and such patients should be followed with periodic calcium determinations. Urgent surgery is required only when acute parathormone poisoning[20] exists and perhaps in the rare cases of carcinoma of the parathyroid. In both

conditions the laboratory findings usually are unequivocal.

Surgical Technique Time Consuming

At exploration, the surgeon must be prepared to spend several hours carefully searching all the usual as well as the unusual locations of parathyroid tissue in the neck. The pathologist should be available for frozen section on all tissue suspected of being parathyroid gland. Operative mortality is negligible and morbidity is low. Transient tetany may develop in 50 per cent of patients but persists in only five per cent. Hypomagnesemia[5] and acute pancreatitis[5] may occur postoperatively but we have not encountered these.

Mediastinal exploration is indicated when neck exploration including total thyroidectomy fails to locate the adenoma. This procedure probably is not indicated in the elderly or debilitated patient because of the greater morbidity and mortality. Otherwise, continuing search for the adenoma should be made to prevent future renal insufficiency.

Once an adenoma has been found, the prognosis in the case of the patient with normal renal function is excellent and recurrences have not been reported.

Summary

A series of 20 cases of primary hyperparathyroidism is reviewed. Urinary calculous disease was the most common clinical syndrome in the series, with thyroid abnormalities the next most frequent. Skeletal changes, when present, were limited to the hands and skull except in the case of one patient with osteitis fibrosa cystica. Peptic ulcer was an uncommon observation.

Hypercalcemia was present in every case and hypercalciuria was absent in only one. Hypophosphatemia and decreased tubular reabsorption of phosphorus were less consistently present. The serum alkaline phosphatase had little diagnostic value.

Eighteen patients underwent exploration of the neck. A single adenoma of the parathyroid gland was found in 14 surgical and two autopsy cases. There was one instance each of double adenoma and hyperplasia of the parathyroid glands. In two cases no pathologic findings were present in the neck.

In 16 of 18 operated patients, the blood chemistry values have returned to normal, including one case of negative findings. The cases of persistent hyperparathyroidism include that of the patient with hyperplasia and that of the other negative exploration.

The screening and diagnostic work-up of patients suspected of having hyperparathyroidism are discussed. The differential diagnosis of hypercalcemia is reviewed and our indications for surgery outlined.

A list of references may be obtained by writing to The Journal.

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Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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VALENTINE 1967

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This is the time of the year for the State Legislature to meet. Are you staying abreast with developments in this session? The State Headquarters Office is keeping you informed. Did you contact your Senator or Delegate when things didn't look good as well as when a good thing, in your mind, was passed?

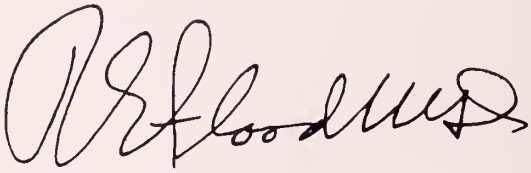
None of us can be too knowledgeable. All of us must know everything we can about what is happening in our town, our State and our nation. *You* can be the best pro or con in the State *if you care* to know what is happening and talk it up.

Many home care units are in existence and are beautifully set up on paper but are getting little play, except for the one in Wheeling. Why? The doctors in Wheeling *know* what it is and what it does. The family physician controls the treatment and the visits.

Some of the committees of the State Association are always meeting; they are quite busy. *All committees* should meet at least once and report accomplishments, even if its just to say "hello" to each other and figure out who'll be the next mayor, governor or president! Seriously, all committees are important and each member should be familiar with the workings because when need calls there is *no time* to learn the rules.

Ed Hagan had himself a baby boy—Phillip Jeffrey—of course, Phyllis was in on that too. We got him baptized on 8 January 67.

To get back to the beginning, Happy Valentine's Day, Abe Lincoln's Day before it, and George Washington's Day after it!



RICHARD E. FLOOD, M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

TAKE HEED, TAKE WARNING, TAKE ADVICE, TAKE CARE

The following lines are excerpted from a presidential address delivered 13 years ago: "I would call your attention to the benefits accrued through periodic physical examination. Each of us can certainly practice what we preach, and if this is sound advice for our patients it should be of equal value to ourselves. I would make a plea to each of my physician listeners that he take time to consider his individual circumstances, that he evaluate and put into effect the many ways in which his time and energy, now partially wasted or ill-used, can be utilized in more lasting benefits to all concerned.

"For those of my physician listeners who, through carelessness or stupid bull-headedness, still insist upon challenging the occurrence of these calculated risks, I have a few words of parting advice. By repeated and longer absences from home you can lessen the void created by your early and untimely departure from this life of stress. Teach your wife, if you can, how to balance a checking account, insist upon her attendance at church or the theatre unaccompanied; give her the privilege of enjoying TV or radio in lonely solitude, give her the responsibility of computing taxes and paying them, and the regular monthly bills. Of special importance these wintry nights will be your removal to a separate bedroom. Let the little woman warm her own feet. Your stern resolve in carrying out this home educational project, with all its morbid connotations, will constitute unquestionable evidence of your determination to sustain the little woman in the lonely hours which lie ahead."

These remarks were made by the voice of experience in matters of morbidity, which as yet have not culminated in a personal mortality statistic. The incentive for such repetitivity is a recent statement made by the President Elect of the American Medical Association and an editorial in the *AMA News*. The conditions which occasioned these remarks in 1953 and 1966 have not changed in identity—they have only become worsened.

Let the readers of this take note of morbid possibilities which can affect their health status, let them take heed of the warnings and advice offered, let them take the steps to determine the presence of incipient or established disability, and, above all, let them take the time and means of assuring themselves the best attainable health.

Come to think about it, this last sentence would make a good prayer to offer for any adult who foolishly refuses to accept the primary principles of self-preservation.

Since there is much discussion of an apparent shortage of physicians in the United States it is of interest that the number of medical graduates is steadily increasing. In a recent datagram released by the Association of American Medical Colleges, provocative data are presented concerning the increase in medical graduates during the last quarter of a century.

INCREASE IN NUMBER OF MEDICAL GRADUATES

In 1940 there were only 77 medical schools in the United States, and of these, 10 offered only two-year programs in the basic medical sciences. The number of students enrolled was 21,271. In 1965 there were 88 medical schools, including three two-year schools, with a student enrollment of 32,428, a 53 per cent increase over the number enrolled in 1940. In 1940 there were 5,097 graduates, whereas in 1965 there were 7,409, an increase of 45 per cent.

It is pertinent to examine briefly how this increase of medical graduates was brought about. Due to the expansion of the 77 schools which existed in 1940, including the transition of seven of the basic science schools to the full four-year medical curriculum (West Virginia University School of Medicine was one of these schools), medical school enrollment increased 7,810 or 35 per cent, and the annual medical graduates increased 2,312 or 30 per cent. This was a very substantial increase.

During the last 25 years, that is, between the years 1940-1965, 11 new medical schools developed. These accounted for an increase in student enrollment of 3,317 or 18 per cent and an increase in annual graduates of 757 or 15 per cent. This means that on the average somewhat less than 70 students were graduated from each school. It is estimated that in 1966, enrollment in medical schools will total 32,873, an increase of 445 over the total enrollment of 1965.

The Association of American Medical Colleges also points out that the creation of 15 new medical schools seems certain in the near future. Of this number 12 will provide the full four-year medical curriculum, and three will offer only the first two years. It is of interest to list these schools and give the names of the cities where they will be located. They are as follows: University of Arizona College of Medicine, Tucson; Brown University Division of Biological and Medical Sciences, Providence, Rhode Island; University of California School of Medicine, Davis; University of California School of Medicine, San Diego; La Jolla; University of Connecticut School of Medicine, Farmington; University of Hawaii School of Medicine, Honolulu; Louisiana State University School of Medicine, Shreveport; University of Massachusetts, School of Medicine, Worcester; Michigan State University College of Human Medicine, East Lansing; Mount Sinai School of Medicine, New York City; State University of New York School of Medicine, Stony Brook, New York; Pennsylvania State University, The Milton S. Hershey Medical Center, Hershey; Rutgers—The State University Rutgers Medical School, New Brunswick, New Jersey; University of Texas South Texas Medical School, San Antonio; Toledo State College of Medicine, Toledo, Ohio.

It is quite apparent that when these 15 medical schools have been developed, the number of medical graduates will be substantially increased. This should materially help alleviate the present shortage of physicians in the United States. Finally, it is extremely gratifying that the State of West Virginia, now that it has established a four-year medical school, is able to play an important part in increasing the number of medical school graduates. It is of interest that the school has specific plans to increase first year enrollment by 10 per cent in 1967.

Computers Are Not Human

Many of the forecasts attributed to Jules Verne (1829-1905) have come to pass. Present-day predictions about the value of computers may some day come to pass as well.

However, it has taken human ingenuity to bring about the prognostications of Verne. It is likewise possible that human ingenuity can make the computer live up to its expectations in medicine. Yet the emphasis should be placed on the important factor in the electronic procedures which is the human brain. Computers are not human. Some human being has to be the programmer who sorts the data originally and feeds it into the machine. The problems of memory and mathematics are readily solved by the computer, but only after the initiation of the process by the intelligence of the programmer.

This stumbling block in medical automation is readily understood by physicians. Any MD who has taken histories from menopausal females realizes it is not easy to assign numerical values to the symptoms. Gastroenterologists evaluating the complaints of patients with ulcers or colitis cannot readily transcribe the symptoms into positive or negative electronic impulses.

While it is possible that programmers in the future can replace the physician, the day is long distant when medical school graduates will be 10 per cent MDs and 90 per cent programmers. For the present, the long suffering physician will have to continue to listen to his patients and evaluate their complaints according to his judgment.

Until the computer researchers can duplicate the human brain, physicians will be essential in the diagnosis of human ills.—*Massachusetts Physician.*

GENERAL NEWS

Education Committee Adopts Tentative Schedule

The Committee on Medical Education and Hospitals of the West Virginia State Medical Association hopes to implement this year its plans for establishing a coordinated program of continuing medical education for practicing physicians in the State.

At a meeting in Charleston on January 8, the Committee decided to sponsor its first postgraduate program in one or more of the eight geographical regions of the State by early fall.

In the meantime, a medical education questionnaire will be mailed to each member of the Association. The purpose of the questionnaire will be to ascertain physicians' present means of obtaining continuing education and to determine how they want education presented in the future.

The questionnaire probably will be mailed out in February and the results will be reviewed by the Committee in April. Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, and Dr. Pat A. Tuckwiller of Charleston, Chairman of the Committee, expressed the hope that each physician will complete the questionnaire and return it to the headquarters office in an accompanying postage-paid envelope.

For the past several months, Doctor Tuckwiller's Committee has been considering the over-all medical education problem. It was decided that any program undertaken by the Committee should be hospital-oriented, using the resources of the West Virginia University School of Medicine, specialty groups, etc.

The Committee tentatively plans to start out with the "wet" type participating program utilizing actual patients in the hospital. Eventually, such other modalities as television, radio and telephone might be utilized.

In order to coordinate these programs once they are undertaken, the Committee has suggested that the Council of the Association propose to the West Virginia University Board of Governors that a position of coordinator of postgraduate programs be established at the WVU School of Medicine.

At a previous meeting of the Committee, Doctor Tuckwiller appointed eight physicians to serve as educational coordinators in eight geographical regions of the State. The coordinators and the counties in their jurisdiction are as follows:

Dr. David Z. Morgan of Morgantown—Monongalia, Preston, Marion, Harrison, Taylor, Tucker, Barbour, Lewis, Upshur, and Randolph counties.

Dr. George Kellas of Wheeling—Wetzel, Marshall, Ohio, Brooke, and Hancock counties.

Dr. F. A. Hamilton of Martinsburg—Jefferson, Berkeley, Morgan, Hampshire, Mineral, Grant, Hardy, and Pendleton counties.

Dr. William E. Gilmore of Parkersburg—Jackson Wood, Wirt, Calhoun, Gilmer, Ritchie, Pleasants, Tyler, and Doddridge counties.

Dr. Edwin M. Shepherd of Charleston—Boone, Kanawha, Putnam, Fayette, Nicholas, Clay, Roane, Braxton, and Webster counties.

Dr. Jack Leckie of Huntington—Mason, Cabell, Wayne, Lincoln, Mingo, and Logan counties.

Dr. Richard G. Starr of Beckley—Raleigh, Summers, Monroe, Greenbrier, and Pocahontas counties.

Dr. Upshur Higginbotham of Bluefield—Mercer, McDowell, and Wyoming counties.

The Coordinators have been surveying hospitals in their areas to determine what educational facilities are available. The Committee plans to sponsor educational programs in some of the smaller community hospitals as well as the larger ones.

Physicians wishing additional information concerning the Committee's proposed program are invited to contact their area coordinators or Mr. William H. Lively, Executive Secretary, West Virginia State Medical Association, P. O. Box 1031, Charleston, West Virginia.

Symposium on Radiology

The Department of Radiology of the University of Kentucky Medical Center will present a symposium on "Current Concepts in Chest Radiology: Pathophysiological Correlations", May 1-5, 1967.

The sessions will end on the eve of the Kentucky Derby.

Radiologic findings will be explained in terms of basic underlying pathological mechanisms. A film seminar will be conducted at the end of each day.

Further information may be obtained by writing to Dr. Harold D. Rosenbaum, Chairman of Radiology, University of Kentucky Medical Center, Lexington, Kentucky.

Pediatric Groups Schedule Spring Meeting

Invitations have been issued to West Virginia physicians to attend the spring meeting of the West Virginia Pediatric Society and the State Chapter of the American Academy of Pediatrics in Morgantown, March 23-24.

The Hon. L. L. Vincent

Mrs. Helen Condry

The session on Thursday will be devoted to a panel discussion of recent health legislation, including the impact on the care of children in West Virginia and the impact on physicians.

Three officials of the State Department of Welfare will participate in the discussion. They are: The Hon. L. L. Vincent, Commissioner; Mrs. Helen Condry, Assistant Director, Division of Family Services; and Mrs. Ethel Cox, Assistant Director, Division of Crippled Children's Services.

Other panelists will include Dr. Jane Freeman, Director of the Division of Maternal and Child Health of the State Health Department and President of the West Virginia Pediatric Society; Dr. Forest Cornwell, Chairman of the State Chapter of the American Academy of Pediatrics; and Dr. W. Gene Klingberg, Chairman of the Department of Pediatrics of the West Virginia University School of Medicine.

There will be a social hour and dinner that evening.

There will be a business meeting of the two pediatric groups on Friday morning, March 24. Dr. James Gillespie, Secretary for Chapters of the American Academy of Pediatrics, will be a guest speaker.

Four members of the faculty of the WVU School of Medicine will conduct a scientific session on Friday afternoon. Dr. Enid Gilbert will conduct a CPC, and papers will be presented by the following:

Dr. Roland E. Schmidt, "Cardiac Examination of the Child"; Dr. Richard C. Juberg, "Genetic Counselling"; and Dr. Barbara Jones, "Hematologic Problems."

The panel discussion on Thursday is scheduled for 1:30 P.M. to 5:00 P.M. The Friday morning business meeting will be from 9 A.M. until noon. The scientific session on Friday afternoon is to begin at 1:30 P.M. and last until 5 P.M.

Category I credit has been requested from the American Academy of General Practice.

A feature of the business meeting will be discussion of the formal organization of the two pediatric groups into one strong, active group.

31st Annual PG Institute In Philadelphia

The Philadelphia County (Pennsylvania) Medical Society will sponsor its 31st Annual Postgraduate Institute at the Bellevue-Stratford Hotel, April 11-14.

Subjects to be covered include: diseases of the stomach and duodenum; genetically determined diseases; newer concepts in hypertensive cardiovascular disease; new horizons in thyroidology; cerebrovascular disease; recent advances in ophthalmologic diagnosis, physical diagnosis from the standpoint of the skin; diseases of coagulation and the use of anticoagulants; and acute pulmonary insufficiency.

The program has been approved for credit by the American Academy of General Practice.

Registration fees are $15.00 per day or $50.00 for the entire period.

Additional information may be obtained by writing to The Philadelphia County Medical Society, 2100 Spring Garden Street, Philadelphia, Pennsylvania 19130.

Advanced Course In Laryngology And Bronchoesophagology

A postgraduate course in laryngology and bronchoesophagology will be conducted in Chicago, April 10-22, 1967.

The program is being sponsored by the Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois.

Registration is limited to 15 physicians. Most of the sessions will be conducted at the Infirmary, and the program will include visits to a number of Chicago hospitals.

Additional information may be obtained by writing to the Department of Otolaryngology, College of Medicine of the University of Illinois, P. O. Box 6998, Chicago, Illinois 60680.

Cleveland Clinic Foundation Lists PG Courses

The Cleveland Clinic Educational Foundation has scheduled five postgraduate courses for February and March.

The programs and their dates are as follows:

February 1-2—"General Practice."

February 15-16 — "Perspectives of Electrophoresis and Clinical Chemistry."

March 8-9—"Advances in Urology."

March 15-16—"Postgraduate Course in Anesthesiology."

March 29-30—"Medical Progress and Its Relationship to Dentistry."

Additional information may be obtained by writing to Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

W. Va. Acad. of Oph.-Otol. Schedules Meeting

The West Virginia Academy of Ophthalmology and Otolaryngology will conduct its 20th Annual Spring Meeting at The Greenbrier in White Sulphur Springs, April 23-27.

Eight out-of-state physicians have accepted invitations to present papers at the meeting.

Additional information may be obtained by writing to Dr. J. Elliott Blaydes, Jr., Secretary-Treasurer, 107 Federal Street, Bluefield.

ACP Lists February-March PG Courses

The American College of Physicians has six postgraduate courses scheduled for February and March.

The schedule for the two months is as follows:

February 6-10—"Biochemical Lesions in Internal Medicine," St. Louis, Missouri.

February 27-March 3—"Arthritis and Related Disorders," New York City.

March 6-16—"Recent Advances in Cardiovascular Disease," New York City.

March 13-17—"Physiological Aspects of Cardiopulmonary Disease," New Haven, Connecticut.

March 20-24—"Fundamental Concepts of Gastroenterology," Ann Arbor, Michigan.

March 27-31—"Psychiatry for the Internist," Detroit, Michigan.

Fees for each program are $60 for members of the ACP and $100 for nonmembers.

Requests for additional information should be sent to: Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

New Orleans Graduate Assembly Schedules March Meeting

The New Orleans Graduate Medical Assembly will conduct its 30th Annual Meeting in New Orleans, March 6-9, 1967.

Papers will be presented by physicians representing anesthesiology, colon and rectal surgery, dermatology, gastroenterology, general practice, gynecology, internal medicine, neurological surgery, obstetrics, ophthalmology, orthopedic surgery, otolaryngology, pathology, pediatrics, radiology, surgery and urology.

The American Academy of General Practice has approved the program for 30½ hours of credit.

The registration fee of $25.00 includes lectures, motion pictures, symposia, CPC, technical exhibits, three round-table luncheons, entertainment for ladies and other features.

Additional information may be obtained by writing to the Secretary, New Orleans Graduate Medical Assembly, Room 1528, 1430 Tulane Avenue, New Orleans, Louisiana 70112.

Dr. Albert C. Esposito of Huntington (seated left), Past President of the West Virginia State Medical Association, is the new President of the Medical Staff of St. Mary's Hospital in Huntington. Also seated is Dr. Frank N. Peck, President Elect of the Staff. Standing (left to right) are: Dr. George Woelfel, Secretary; Dr. Winfield C. John, retiring Secretary; and Dr. James A. Hickman, retiring President.

New Association Members

Dr. William M. Clopton, 112 Ann Street, Beckley (Raleigh). Doctor Clopton, a native of Lynn, Massachusetts, was graduated from the University of Virginia and received his M. D. degree in 1935 from the University of Virginia School of Medicine. He interned and served a residency at Barnes Hospital in St. Louis, and also served a residency at Boston City Hospital in Boston, Massachusetts. He was previously located in Washington, D. C., and Las Vegas, Nevada, and his specialty is radiology.

* * * *

Dr. Frank S. French, Route 1, Box 155 C., Martinsburg (Eastern Panhandle). Doctor French, a native of New York City, was graduated from Cornell University and received his M. D. degree in 1931 from the Cornell University Medical College. He interned at Clifton Springs Sanitarium Clinic in Clifton Springs, New York, and served a specialty internship in medicine at St. Vincent's Hospital in New York City. He practiced in Rochester, New York, until 1942 when he entered active duty with the Medical Corps of the United States Army. He was released in 1946 with the rank of Major. He served with the United States Public Health Service from 1947 to 1963. His specialty is internal medicine.

* * * *

Dr. Meredith Rohani, 1007 South Oakwood Avenue, Beckley (Raleigh). Doctor Rohani, a native of Tehran, Iran, was graduated from Elborz College and received his M. D. degree in 1957 from the University of Tehran. He interned at Homer G. Phillips Hospital and served residencies at that hospital and Colorado State Hospital and Beckley Hospital. His specialty is surgery.

The Medical Society of West Virginia (1901-1905)

At the Annual Meeting of the Medical Society of West Virginia, May 22-24, 1901, in Grafton, 75 members were present. President A. H. Thayer digressed from the usual type of presidential address to give a scientific essay on "The Prevalence of Small-pox in West Virginia." This talk was short, but provoked a lively discussion and again a resolution was passed urging the State to provide compulsory vaccination.

The health of the Society members was excellent. For the only year on record, there was no necrology report, because there were no deaths in the past year. There were 306 active members and 19 honorary members. Surely, the Necrology Committee was sidestepping its job.

There were at that time 38 counties represented in the Medical Society of West Virginia and the Taylor County Medical Society was admitted to affiliation in 1901. Resolutions were passed to ease the formation of county societies and to permit the county members to become State Society members without further investigation and delay.

The rules stated that papers must be limited to 20 minutes, except by consent, and a copy of every paper must be sent to the Publication Committee for publication in the Transactions (The present Publication Committee would like to have the Committee on Constitution and By-Laws consider reenactment of this rule). In 1901, however, no lantern slides were used. This devious practice did not develop until 1902. Because the secretarial reporting was too brief, the Society decided to employ a stenographer for the benefit of the future record.

It is interesting to note that all meetings combined business and medicine. There was no Council or House of Delegates. Delegates were appointed to Society meetings in Maryland, Pennsylvania, Kentucky, Virginia, Ohio and the Mississippi Valley. Because there was a treasury balance of $58.02, and the dues were only $2.00, it is probable that all delegates traveled on their own pocket book. There were 30 delegates appointed to the AMA session in 1901.

The rolls now show familiar names, some of whom were personal friends of this aged archivist. If there were any business or committee meetings between annual sessions, the records of the transactions do not disclose such affairs.

At the Annual Meeting in Parkersburg in May of 1902, 111 members answered the roll call. The records show no indication of daytime diversion, such as golf, tennis, skeet, et cetera, et cetera, so this number (111) will compare favorably with any recent business or scientific session and exceed in attendance 90 per cent of the meetings of the past 25 years. There was an address of welcome from the mayor and some "words of welcome" from Dr. T. A. Harris (Could this be our elder statesman?)

Eighty-one applications were reviewed. Eighty-one doctors were elected to membership.

The State Health Department was still recalcitrant and the Society once again passed a resolution urging a medical law to permit only medical graduates to take the licensing examination.

Something new was added by the Committee on Arrangements: Symposium on Tuberculosis. It was so well accepted that a resolution was passed urging all future program arrangers to have a symposium. There were two visiting speakers and they came with photographs and lantern slides. One may from here, 1902, note a decadence in the quality of medical oratory. A good feature was a resolution stating that each year there shall be a lecture on a subject of general public medical interest to which the public shall be invited.

The doctors unanimously voted to urge the Legislature to establish a tuberculosis sanitorium. There was a comprehensive, detailed secretarial report of this meeting and a directory of physicians was planned for the coming year.

In the minutes of the previous Transactions, we have missed any reference to a Committee on Reorganization. In 1902, a report was made. This report of the committee presenting a new constitution and by-laws was adopted unanimously and now we are going modern. The Medical Society of the State of West Virginia is now the West Virginia State Medical Association. There is created three vice presidents and a Council. The Council consists of two councillors from each Councillor District, but the districts are not given cartographic description. We now have not 30 but one AMA delegate and he will continue to pay his own freight for another 55 years. The councillors fared better; they collected expenses on all official business, except the Annual Convention.

Local societies now in affiliation with the State Society are Ohio, Harrison, Taylor, McDowell, Huntington, Jefferson and Marion. Also there was the Charleston Medical Society.

The Board of Censors admonished the members to live up to the Code of Ethics and refrain from indulgence in newspaper notoriety.

Charleston and Fairmont invited the Association for the next Annual Meeting and Charleston won.

President Aschman of Wheeling, in his Presidential Address, urged reorganization and strengthening of state and county societies and stated that the State Association should follow closely the recommendations of the National Committee of the AMA. These recommendations are still applicable to medical societies in 1967. There were now 381 members.

The year 1902 was a great one for the State Medical Association.

The 36th Annual Session was held in Charleston in May 1903. Dr. H. B. Stout, President, was in the chair. Ninety-one members were registered and 34 applicants were elected to membership. The Association granted financial amnesty to all members in arrears, but warned the members that henceforth, failure to pay dues would result in loss of membership. The constitution and by-laws were again amended to conform to the AMA constitution.

The Little Kanawha-Ohio Valley Medical Society, comprising many counties, had by far the largest membership.

This either was a dull session or it was poorly reported.

The 37th Annual Session was held at Fairmont in May of 1904. Dr. T. L. Barber, the President, was in the chair. Registration totaled 115. The House of Delegates meeting was postponed several hours because of lack of quorum.

In his Presidential Address, Doctor Barber made many important suggestions. A national board of licensure was recommended and it should emanate from the State Association through the AMA. This was a very forward-looking suggestion. Apparently no other society had promoted this interest. Doctor Barber felt strongly that here was an opportunity for the State Medical Association to be number one in the nation. The President had plans whereby dues could be effected and expressed a hope that such a board would replace all state and local licensing and permit physicians to move as they worked throughout the country. For the first time the employment of a man to organize the State Association was strongly recommended. Such a person would be field secretary of the Association and Editor of a State Journal that would replace the annual Transactions.

There was passed a resolution pledging moral support and substantial defense of any member who is sued; furthermore, all members were pledged to serve at the trial and testify in the behalf of any member who is sued.

Now the Committee on Constitution and By-Laws recommended the establishment of a House of Delegates. A couple of mavericks from Harrison County wanted the right of making and retaining members who did not wish to be members of the State Association. After deliberation, this request was withdrawn. There was a long harangue on a legislative proposal to tax physicians and surgeons $10 per annum for an annual license. In his Presidential Address, Doctor Stout was all for orderly procedure and further organization of the Association. He requested a resolution stating that intoxicating beverages should not be used at the annual banquet.

There were now 10 county societies. The Huntington County Medical Society became the Cabell County Society. The Charleston Society was now the Kanawha Society. The President decried the practice of securing business through systematic advertisement of a commission for all cases sent to an individual or hospital. But he stated, "Such consulting physicians or specialists who are inclined to charge rather heavily for their services, perhaps feeling that the physician who brings the case to them has sacrificed prospective fees by so doing, is disposed to equalize matters by paying the physician a commission on the fees they received. If such reimbursement is made at the time of consultation or operation without any promise of pre-arrangement, I cannot see any impropriety in it unless it becomes a constant practice."

The public address of the year was given by Dr. S. L. Jepson of Wheeling on the subject, "Suicide." This was an excellent talk and could be reprinted to date with little change or interpolation.

There were now 13 county or affiliated societies and 541 members.

The House of Delegates met for the first time and the by-laws were promptly amended to read: "The House of Delegates and councillors present shall constitute a quorum." Also, each county society was permitted to have one delegate and one delegate for each 25 members or fraction above 20.

The 38th Annual Session was held in Wheeling, May 24-26, 1905. Dr. T. M. Hood, the President, was in the chair. Eighty-four members were registered.

The House of Delegates conducted the business of the Association. The House was now well organized and did its business with dispatch. The major item of business concerned the appeal of three practitioners in Harrison County who, rejected by the Harrison County Medical Society, appealed to Council and House of Delegates for redress. The Council in secret session upheld the County Society.

The President stated in his address that 115 members were present which was the largest attendance in any of the 37 previous annual sessions. Doctor Hood stated that on February 28, 1867, a few physicians gathered at the McClure Hotel in Wheeling to consider the formation of a State Medical Society. A circular signed by 16 physicians, eight of them from Ohio County, was addressed to the prominent medical men throughout the state. The organization was completed in Fairmont on April 10, 1867, and the first regular meeting was held in Wheeling, in October of the same year.

Doctor Hood's presidential remarks pertained to preventive medicine and inebriety.

Dr. Lind, of New Richmond, gave the public address on Tuberculosis. The emphasis was on public health and prevention. The meeting was well attended and the oration well received.

The Annual Symposium on Pneumonia and the report on the antipneumococcus serum was not encouraging. Mortality was still 13 to 20 per cent. In another paper on tuberculosis, Dr. H. Wilson again urged the establishment of a sanitorium.

The last year of the Transactions was 1905. The Publication Committee in 1906 was directed to produce a West Virginia Medical Journal. Several items from that Journal were reproduced in the November 1966 issue.

(TO BE CONTINUED)

Strep Infections Beginning Upward Trend

The number of cases of streptococcal infections should begin increasing and reach its peak in late winter and early spring, according to State Health Director N. H. Dyer.

In a recent issue of the "State of the State's Health," Doctor Dyer said streptococcal infections are known to trigger a reaction in many patients resulting in rheumatic fever and, its more dangerous aftermath, rheumatic heart disease. Since this strep infection can be easily identified, the health officer said, it offers a main target of attack in programs of prevention.

Doctor Dyer noted that more than five years ago, the State Health Department, in cooperation with the Kanawha Valley Heart Association, launched a demonstration program for a rapid detection of strep infections aimed specifically at identification of the one class of dozens of species of streptococci responsible for the rheumatic reaction—beta hemolytic group A.

Known as the fluorescent antibody technique, he explained, the procedure employs modern laboratory methods that cut the time required for reporting the presence of group A strep to physicians from several days to about 24 to 48 hours.

"This rapid identification is a definite aid to diagnosis for the physician," Doctor Dyer said. "It provides information during the time of the patient's acute illness when it can be of greatest help to the physician in determining the needed therapy. Strep infections require a minimum of 10 days of antibiotic therapy, while many other sore throats require much less. Inadequate therapy in patients with strep A can effectively mask clinical evidence of infection while the bacteria continue to produce untoward manifestations in the body."

Doctor Dyer mentioned that the rapid detection service has been extended to all practicing physicians in the State. He said that in order to make the service easier to use and closer at hand for physicians, regional laboratory facilities are being established. In addition to the State Hygienic Laboratory in South Charleston, laboratory facilities have already been established at the Wheeling-Ohio Health Department and the Mercer County Health Department.

"Specimens are returned to the laboratory in kits that are unbreakable, easily portable and can be mailed in an ordinary envelope with minimum postage," Doctor Dyer noted. "The positive findings are then reported by telephone to the local health department. The specimen kits, known as 'Culpac Kits,' are available to the physician from the laboratories on request, as specimens are submitted, or from the local health department, thereby providing continuous, uninterrupted service."

Doctor Dyer reported 44 counties participating in the service during the 1965-66 fiscal year submitting 7,602 specimens for analysis. He said approximately 80 private physicians were routinely using the service.

"Based on the findings from the specimens submitted," Doctor Dyer noted, "the prevalence of group A beta hemolytic strep has been found to be greater than anticipated and still remains a problem in West Virginia."

"None of these findings can be treated lightly," the health officer stated. "Although only about three per cent of patients with symptoms distinguished on clinical grounds can be expected to experience the rheumatic reaction without adequate therapy, authorities hold that any person with a strep A infection is a potential candidate for rheumatic fever and rheumatic heart disease."

Doctor Dyer also explained the rheumatic fever control program of the Bureau of Heart Disease Control which aids indigent and medically indigent patients who have previously had rheumatic fever through penicillin prophylaxis.

The health official explained that the project has operated since September, 1952, with aid from the West Virginia Heart Association. He reported that as of September 1, 1966, 2,318 patients were being supplied drugs regularly.

"These drugs are furnished through local health departments to be dispensed following the submission of an application to the Bureau of Heart Disease Control by a physician," Doctor Dyer said.

"Some authorities believe that once a patient has experienced an attack of rheumatic fever, lifelong drug prophylaxis is indicated," Doctor Dyer commented. "Most physicians are agreed that drugs must be taken to prevent recurrent attacks into late adolescence or early adulthood. Recurrent rheumatic attacks may occur in up to 50 per cent of these patients who do not remain on prophylaxis."

"Rheumatic fever and rheumatic heart disease were listed among the 10 leading causes of death in West Virginia as late as 1963," Doctor Dyer declared, "even though many people apparently believe these diseases are no longer a significant problem. This misconception may be due to the fact that present knowledge of prevention makes rheumatic heart disease the most preventable of the major cardiac conditions. Although the knowledge of how to prevent the disease may lessen anxiety concerning it, only the widespread application of the knowledge of prevention will benefit our population."

Another $500 Contribution To Scholarship Fund

Mr. Harry H. Carnahan, President of The Medical Arts Supply Company in Huntington, has made a contribution of $500 to The Charles Lively Memorial Scholarship Fund of the West Virginia State Medical Association. This is the ninth consecutive year that Mr. Carnahan has contributed the sum of $500 to the Scholarship Fund.

Under the program, 14 students already have been awarded scholarships of $4,000 each to the West Virginia University School of Medicine.

Doctor Coyner Named Member Of Key AMA Council

Dr. Martha Jane Coyner of Harrisville has been appointed a member of the Council on Rural Health of the American Medical Association. Announcement of her appointment was made on December 15 by the Board of Trustees of the AMA.

Martha J. Coyner, M. D.

Doctor Coyner, who has practiced in Harrisville since 1954, has served as Chairman of the Rural Health Committee of the State Medical Association for the past three years.

Doctor Coyner was born in Buckhannon and was graduated from West Virginia University. She attended the two-year WVU School of Medicine and received her M.D. degree in 1952 from the University of Pittsburgh School of Medicine. She served an internship at the Ohio Valley General Hospital in Wheeling and was licensed to practice in 1953.

Doctor Coyner is a member of the Medical Advisory Board of the Sears-Roebuck Foundation.

The AMA Council on Rural Health is composed of 10 members and the Chairman is Dr. Ben N. Saltzman of Mountain Home, Arkansas.

In addition to her duties as Chairman of the Rural Health Committee of the State Medical Association, Doctor Coyner has been active in the affairs of the West Virginia Chapter of the American Academy of General Practice. She was named President Elect of the organization during the 1966 annual meeting and will assume the Presidency at the 1967 meeting which will be held in Huntington.

Clinical Problems of the Newborn

The Fifth Annual Seminar on "Clinical Problems of the Newborn" will be held at Good Samaritan Hospital in Cincinnati on April 13.

No registration fee will be charged.

Physicians interested in attending should contact Dr. Charles V. Pfahler, Department of Pediatrics, Good Samaritan Hospital, Cincinnati, Ohio 45220.

Cardiac Symposium in Washington

The Heart Association of Northern Virginia and the Washington Heart Association will sponsor their 10th Annual Joint Cardiac Symposium on April 27.

The session will be held at the Marriott Twin Bridges Motor Hotel on U.S. Route 1 in Washington.

Additional information may be obtained by writing to Mrs. Anna C. Van Sickler, 609 North Edgewood Street, Arlington, Virginia 22201.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1967

Feb. 9-15—AMA Cong. on Med. Ed., Chicago.
Feb. 14-19—Am. Col. of Cardiology, Washington.
Feb. 18-22—Am. Acad, of Allergy, Palm Springs, Calif.
Feb. 23-25—Cen. Surg. Assn., Pittsburgh.
Feb. 28—Nat. Multiple Sclerosis Soc., New York.

March 6-9—New Orleans Grad. Med. Assembly, New Orleans.
March 9-11—AMA-ABA National Medicolegal Symposium, Miami Beach.
March 10-11—AMA Conf. on Rural Health, Charlotte, N. C.
March 12-15—Int Acad. of Path., Washington.
March 16-18—Sou. Soc. of Anesthesiologists, Charleston, S. C.
March 19-24—Southeastern Surgical Cong., Bal Harbour, Fla.
March 19-24—Am. Col. of Allergists, New Orleans.
March 23-24—W. Va. Ped. Soc., and W. Va. Chap., Am. Acad. of Ped., Morgantown.

April 3-5—Am. Acad. of Ped., San Francisco.
April 7-9—Am. Soc. of Int. Med., San Francisco.
April 10-13—Indus. Med. Assn., New York City.
April 10-14—Am. Col. of Physicians, San Francisco.
April 11-13—Am. Surg. Assn., Colorado Springs.
April 17-20—Am. Col. of Ob. and Gyn., Washington.
April 17-19—Am. Assn. for Thoracic Surgery, New York.
April 19-21—Maryland Medical, Baltimore.
April 23-26—W. Va. Acad. of Oph. and Otol., White Sulphur Springs.
April 24-29—Am. Acad. of Neurology, San Francisco.
April 24-26—AMA Nat. Cong. on Environment Health Management, New York City.
April 27-28—Am. Ped. Soc., Atlantic City.
April 30-May 2—W. Va. Chapter, AAGP, Huntington.
April 30-May 5—Int. Col. of Surgeons, Bal Harbour, Fla.

May 2-3—Assn. of Am. Phys., Atlantic City.
May 3—Am. Cancer Soc., Dallas.
May 4-6—Am. Gynecological Soc., Phoenix.
May 6—Am. Col. of Psychiatrists, Philadelphia.
May 7-12—Am. Psy. Assn., Detroit.
May 11-14—Am. Surg. Assn., Colorado Springs.
May 16-19—Ohio Medical, Columbus.
May 28-June 1—Am. Dermatological Assn., Colorado Springs.
May 29-31—Am. Oph. Soc., Hot Springs, Va.
May 29-June 1—Am. Urol, Assn., New York.
May 21-24—Am. Thoracic Soc., Pittsburgh.

June 15-17—Am. Col. of Chest Phys., Atlantic City.
June 16-17—Am. Geriatrics Soc., Atlantic City.
June 17—Acad. of TB Phys., Atlantic City.
June 17-18—Am. Diabetes Assn., Atlantic City.
June 18-22—AMA Annual Con., Atlantic City.
June 26-29—Am. Orthopaedic Assn., Hot Springs, Va.
July 14-15—Rocky Mtn. Cancer Conf., Denver.

Aug. 24-26—100th Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.

Aug. 27-Sept. 1—Am. Acad. of Phys. Med. & Rehab., Miami Beach.
Sept. 29-Oct. 1—W. Va. Heart Assn., Wheeling.

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Edward E. Cale, M. D.
Malcolm G. MacAulay, M. D.
Don L. Weston, M. D.
J. William Giesen, M. D.

Clinical Psychology:
Thomas C. Camp, Ph. D.
Card McGraw, Ph. D.
David F. Strahley, Ph. D.

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Pierce D. Nelson, M. D.

The Month in Washington

• **From the Washington Office of the American Medical Association.**

At a cost of nearly $1 billion, more than six million older persons got hospital and medical benefits during the first six months of the medicare program. Social Security Commissioner Robert M. Ball expressed satisfaction with the over-all operations so far of the health insurance program for the elderly. But Mr. Ball warned of bed shortages in the nation's capital, in various New England states, and in most rural areas when a new medicare benefit of nursing home care went into effect on January 1. He estimated that from 50,000 to 60,000 beds would be needed for extended care in nursing homes.

The Commissioner recommended a number of changes in the program:

—He urged that medicare benefits, which apply to persons 65 or older, be extended to 1.3 million disabled persons.

—He said the major improvement needed in the Social Security program is an "across-the-board" increase in benefits. Over-all benefits to be paid out in 1966 will rise from $21 billion in 1966 to $25 billion in 1967, he noted. President Johnson has announced he will seek a boost of about 10 per cent in Social Security benefits in the next Congress.

Ball's report on the first six months of medicare included:

—About 2.5 million elderly persons received free hospital care and 3.5 million benefited from medical services.

—Since medicare began July 1, 1966, hospital occupancy increased five per cent, as expected. Thirty per cent of all hospital beds were occupied by those 65 or older at the end of 1966.

—About 6,700 hospitals now are participating in medicare. About 250 hospitals were excluded because they did not meet minimum standards, and 75 hospitals because of racial discrimination.

—Payments to doctors and skilled medical personnel, such as radiologists, have taken too long.

—Overcrowding of hospitals in various "isolated" incidents.

—Almost all of 17.5 million persons who signed up for additional medical insurance at a premium of $3 maintained their payments.

Seventeen hospitals in five states declared ineligible for federal funds because of failure to comply with provisions of the 1964 Civil Rights Act were granted public hearings by the Public Health Service in Alabama, Louisiana, Mississippi, South Carolina and Texas.

"Discriminatory practices found at the hospitals include the segregation of patients . . . an absence of Negro physicians . . . and the segregation of training facilities," a PHS spokesman said.

Sen. George D. Aiken, R., Vt., proposed a nine-point program to liberalize benefits under the government's medicare plan for action by Congress. One would extend medicare drug coverage to prescriptions for old people whether or not associated with hospital confinement. A similar plan was included in a Senate-passed tax bill last summer but was killed in a Senate-House conference. Other Aiken proposals would eliminate deductible and co-insurance features, waiting periods and enrollment deadlines from the medicare plan, lower the 65 year age requirement for women to 62, and permit payment of medical specialist fees customarily provided by hospitals.

'Progress Against Cancer'

The National Advisory Cancer Council reported that, although cancer is still on the increase, more people are being cured of it than ever before.

The report—titled "Progress against Cancer"—shows that 30 years ago there were 144,774 cancer deaths in the United States, a crude rate of 112.4 per 100,000 of the population. In 1967, an estimated 305,000 deaths will occur, bringing the rate up to 153 per 100,000, according to the report. On the other hand, there has been an improvement in the cure rate. In 1937, less than one in five cancer patients survived five years without evidence of disease, but currently about 35 per cent, or better than one in three are saved. There is good reason to believe, the report states, that this favorable trend will continue.

Intensive study of six types of cancer is recommended:

Cancer of the breast, which has shown little improvement in incidence or mortality for about 30 years; the lymphomas, one of which, Hodgkin's disease, has been cured in 40 per cent of cases in a localized stage; chronic leukemia and multiple myeloma, for which drug treatment should be greatly improved; lung cancer, which continues to increase, particularly in both men and women smokers; and uterine cancer, which has been significantly reduced and might be almost totally eradicated by early detection with the "Pap" smear.

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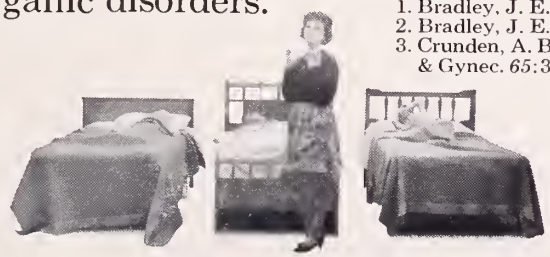
1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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Obituaries

JOSEPH EARLE PAGE, M. D.

Dr. Joseph E. Page of Clarksburg died at his home in that city on December 13. He was 84.

At native of New Philadelphia, Ohio, he was graduated from Sico College in Ohio and the University of Pittsburgh College of Pharmacy. He received his M. D. degree in 1906 from Maryland Medical College.

He interned at Franklin Square Hospital in Baltimore and received postgraduate training in anesthesiology at McKessons Hospital in Toledo, Ohio.

He was an honorary member of the Harrison County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Mary Kramer Page, one brother, Marcus A. Page of St. Petersburg, Florida; and a sister, Mrs. John Morgan of Arlington, Virginia. A nephew, Mr. Hart F. Page of Columbus, is Executive Secretary of the Ohio State Medical Association.

★ ★ ★ ★

GUY R. POST, M. D., M. P. H.

Dr. Guy R. Post, 76, of Fairmont, Director of the Marion County Health Department, died unexpectedly on Christmas Eve while visiting at the home of his son and daughter-in-law in Eugene, Oregon.

A native of Roanoke, West Virginia, Doctor Post attended Glenville State College and received his M. D degree in 1916 from the University of Maryland School of Medicine. In 1939, he received the degree of Master of Public Health at Johns Hopkins University.

He served an internship at Mercy Hospital in Baltimore and did postgraduate study at the schools of medicine of West Virginia University, the University of Maryland, Western Reserve University, Tulane University and Johns Hopkins University.

In 1965, he was named a Fellow of the Royal Society of Health. He was an honorary member of the Marion County Medical Society, the West Virginia State Medical Association and the American Medical Association.

He was President and Secretary of the old Lewis County Medical Society; President of the Neyvaygo County Medical Society in Michigan; President of the Coohoma County Medical Society in Mississippi; and Secretary and Treasurer of the Clarksdale Medical Society in Mississippi.

Survivors include the widow; the son, Dr. William Post of Eugene, Oregon; a sister, Mrs. Gilbert Hershman of Weston; and three grandchildren.

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WILLIAM LAWRENCE VAN SANT, M. D.

Dr. William L. Van Sant, 83, of Hinton, died in Hinton Hospital on January 6 after suffering a heart attack at his home.

A native of Virginia, Doctor Van Sant attended Virginia Tech and the Medical College of Virginia before

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receiving his M. D. degree in 1910 from the University of Maryland School of Medicine.

Although he retired from the active practice of surgery several years ago, Doctor Van Sant remained active in the management of Hinton Hospital, of which he was principal owner. He was recognized as one of the Hinton area's outstanding civic leaders.

During World War I, he served in the Medical Corps of the United States Army.

He was an honorary member of the Summers County Medical Society, the West Virginia State Medical Association and the American Medical Association. His other professional memberships included the International College of Surgeons and the Southeastern Surgical Association. He was President of Summers County Medical Society in 1947-51.

Survivors include the widow, the former Agnes Brown; two sons, William L., Jr., of Annandale, Virginia, and Marshall of Florence, Alabama; a daughter, Miss Van Sant of Chapel Hill, North Carolina; and three grandchildren.

★ ★ ★ ★

PAUL PELLEY WARDEN, M. D.

Dr. Paul P. Warden, 72, a former member of the Council of the West Virginia State Medical Association, died in a Grafton hospital on December 13 following a long illness.

A native of Grafton, he was graduated from West Virginia University and attended the two-year WVU School of Medicine. He received his M. D. degree in 1921 from Jefferson Medical College.

He interned at Allegheny General Hospital in Pittsburgh and established his practice in Grafton in 1922. He practiced in Grafton for 40 years and was active in civic and public affairs in that community. He served as Mayor of Grafton, 1961-62.

He served terms as Secretary and President of the Taylor County Medical Society and he was an honorary member of that Society, the West Virginia State Medical Association and the American Medical Association.

His widow, Mrs. Eleanor Metzner Warden, is a Past President of the Woman's Auxiliary to the West Virginia State Medical Association.

Besides the widow, he is survived by a daughter, Mrs. Earl Slaughenhoupt of Bridgeport; a son, Charles A. Warden of Glastonbury, Connecticut; and six grandchildren.

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County Societies

CABELL

Dr. William L. Neal of Huntington was elected President of the Cabell County Medical Society during the regular monthly meeting which was held at the Hotel Frederick on November 10.

He succeeds Dr. Joseph Farrell.

Other new officers for the coming year are: Dr. John Otto, President Elect; Dr. Robert Hibbard, Vice President; Dr. Harold Kagan, Secretary; and Dr. David Haught, Treasurer.

Mr. Robert N. Campbell of Charleston, West Virginia Medicare Manager for Nationwide Insurance Company, was guest speaker. He reviewed the essentials in the care of medicare patients and stressed the necessity of giving details regarding treatment.

Doctor Haught reported that 92 physicians attended the Society's Annual Symposium.

Forty-five members and guests attended the meeting. —Harold N. Kagan, M. D., Secretary.

* * * *

KANAWHA

Dr. Joseph A. Smith of Dunbar was elected President of the Kanawha Medical Society during the group's regular monthly meeting in Charleston on December 13.

He succeeds Dr. George R. Callender, Jr., of Charleston.

Doctor Smith and other new officers were installed during the Society's annual dinner-dance at the Daniel Boone Hotel on January 14.

Serving with Doctor Smith are: Dr. E. Q. Hull, Vice President; and Dr. A. Thomas McCoy, Secretary-Treasurer.

Doctor Smith is a former President of the West Virginia Chapter of the American Academy of General Practice.

* * * *

MONONGALIA

Dr. W. E. King was elected President of the Monongalia County Medical Society at the regular monthly meeting in Morgantown on December 6.

Other new officers are: Dr. A. W. Kelley, Vice President; Dr. Robert Greco, Secretary; and Dr. John Trotter Treasurer.

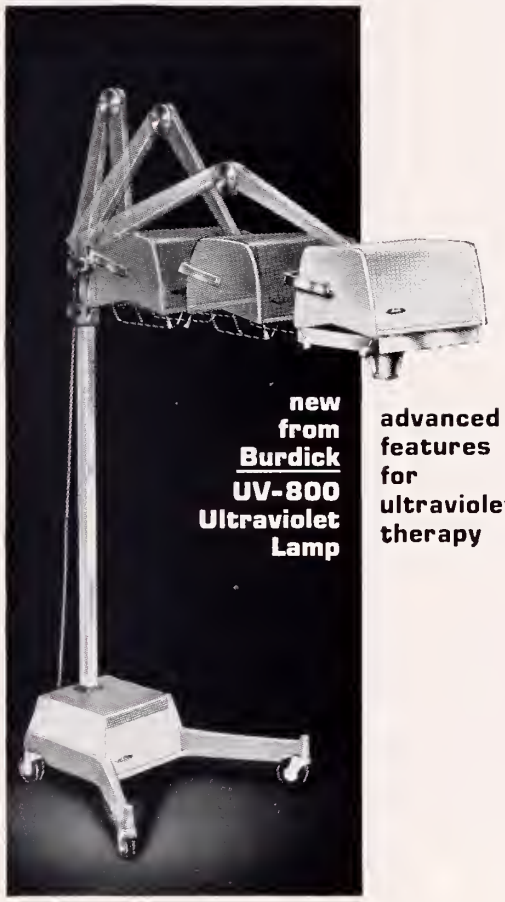
Doctor Trotter introduced the new County Health Officer, Dr. I. A. Wiles.

Forty members and two guests were present.—Robert Greco, M. D., Secretary.

* * * *

PARKERSBURG ACADEMY

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, and Mrs. Hu C. Myers of Philippi, President of the Woman's Auxiliary to the Association, were guests of honor



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Daniel W. Dickinson, M. D

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Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.
Hugh R. Holtrap, M. D.

Urology:
Richard D. Gill, M. D.
D. C. Trapp, M. D.

Neurological Surgery:
Frank M. Hudson, M. D.

Dermatology:
H. L. Saferstein, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

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Donna Bryan, M. T.

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Electrocardiography:
Betty Bartsch, R. N.
Electroencephalography:
Joann Green, R. N.
June Althar, R. N.
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at a dinner dance sponsored by the Parkersburg Academy of Medicine at the Chancellor Hotel in Parkersburg on January 12.

In brief remarks, Doctor Flood mentioned some of the services that the State Medical Association and the American Medical Association are providing their members.

Four members of the Academy were presented plaques in recognition of their long service to medicine and humanity. They are Drs. Orva Conley of Parkersburg, R. C. Newman of Spencer, S. M. Prunty of Parkersburg and Russell H. Paden of Parkersburg. Each has practiced medicine for 50 years or more.

Dr. Dwight P. Cruikshank, President of the Academy, announced that a member, Dr. Martha J. Coyner of Harrisville, had been appointed recently to the AMA Council on Rural Health.

* * * *

WYOMING

Dr. Ross E. Newman of Mullens was elected President of the Wyoming County Medical Society at a meeting held at Wyoming General Hospital in Mullens on December 30.

He succeeds Dr. Aarom Boonsue.

Other new officers include: Doctor Boonsue, Vice President; and Dr. Frank Zsoldos of Mullens, Secretary-Treasurer.—George F. Fordham, M. D., Secretary.

Radiology:
KARL J. MYERS, M. D.

Pathology:
S. D. WU, M. D.

Surgery:
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.

Gynecology and Obstetrics:
RAYMOND W. CRONLUND, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
ERNEST G. GUY, M. D.
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Book Reviews

A MANUAL OF TROPICAL MEDICINE—By George W. Hunter, III, Ph. D., Col. U. S. A. (Ret.); William W. Frye, Ph. D., M. D., Sc. D. (Hon.) and J. Clyde Swartzwelder, Ph. D. W. B. Saunders Company, Philadelphia, London. 1966. Pp. 931. Illustrated. Price: $18.50.

This fourth edition of a classic treatise on Tropical Medicine has 38 outstanding contributors. There are 323 illustrations, eight in color with a preface to the fourth edition, acknowledgements for the fourth edition, and a listing of references.

The book is divided into 12 sections with 76 chapters, plus an appendix and an index. The sections are: Virus Diseases; Rickettsial Diseases; Spirochetal Diseases; Bacterial Diseases; Mycotic Diseases; Protozoal Diseases; Helminthic Diseases; Nutritional Diseases; Miscellaneous conditions; Medically Important Mollusks; Medically Important Arthropods; and Some Laboratory Diagnostic Methods. In addition to a very systematic and complete coverage of the subject of each chapter there is, at the end of each chapter, a list of references.

The book is composed of 871 pages of text, plus 25 pages of appendix covering the distribution of selected communicable diseases in the tropical and subtropical areas of the world, and 32 pages of very adequate index. The clear type on excellent, glossy paper, plus the excellent applicable photographs, micro-photographs, illustrations, charts, and maps make study and perusal of this book a pleasure to even the uninitiated.

To this reviewer whose major experience with tropical diseases occurred nearly 30 years ago, the scope and coverage of this Fourth Edition is fascinating and somewhat astounding. Of particular interest is the 12th chapter on Laboratory Diagnostic Methods and Procedures and the appendix covering the distribution of Selected Communicable Diseases in the Tropical and Substropical Areas of the World.

With tourism on the increase to all parts of the tropical world, with immigration from the tropics and the orient, with exchange students coming and going and United States citizens returning from areas of work abroad, as well as with the return of soldiers from Viet Nam potentially bringing tropical diseases with them, it behooves the medical profession in even non-tropical West Virginia to become alert to the possibility of encountering tropical diseases in our own patients.

General Blount states in the Foreword: "This superb volume should contribute to significant improvement in levels of medical practice in the tropics and subtropics."

It would seem to this reviewer that the book deserves a place on the desk or in the library of every practitioner of medicine, for it is not only interesting and delightful reading but a great source of reference and comfort when one is confronted by the puzzling problem of a patient with a possible tropical disease as the cause for unexplained symptoms.—E. Lyle Gage, M. D.

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Vol. 63 No. 3

The
WEST VIRGINIA
Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston, W. Va. 25324

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50c per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

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The West Virginia Medical Journal

Vol. 63, No. 3 March, 1967

Pseudocyst of the Pancreas*

Carlos H. Boetsch, M. D.

The purpose of this paper is to report the surgical management of pancreatic pseudocyst in Charleston Memorial Hospital. This includes only a limited number of cases, but represents the experience of a community hospital with this rather unusual lesion. Howard and Jordan reported an average incidence of only 0.007 per cent from a collected study of 2,142,631 hospital admissions. Among 140,180 hospital admissions, we found seven pancreatic pseudocysts.

Lesion Defined

Pancreatic pseudocyst has been defined as a cavity delineated by a fibrous wall without epithelial lining, in or adjacent to the pancreas. The entity accounts for most of the cystic lesions of the pancreas, representing, in varied form, approximately 70 per cent of all cysts.

The form (or classification) noted here was proposed by Howard and Jordan, and is based on etiologic factors. It has the merit of being simple and self-explanatory.

1. Postinflammatory.
   a. Acute pancreatitis.
   b. Chronic, relapsing pancreatitis.
2. Post-traumatic.
   a. Blunt.
   b. Penetrating.
   c. Operative.
3. Neoplasm.
4. Parasites (Ascaris lumbricoides).
5. Idiopathic.

Pathogenesis.—In formation of the pancreatic pseudocyst, inflammatory reaction, local necrosis and a variable degree of local hemorrhage seem to be essential factors.

*Presented before the Annual Meeting of the West Virginia Chapter of the American College of Surgeons at The Greenbrier in White Sulphur Springs on April 15, 1966. Doctor Boetsch was awarded second prize in the competition among residents who presented papers.

Submitted to the Publication Committee, September 8, 1966.

The Author

- **Carlos H. Boetsch, M. D., Formerly Chief Resident in Surgery at Memorial Hospital in Charleston, West Virginia, and now serving a Residency in Thoracic Surgery at University of Maryland Hospital, Baltimore, Maryland.**

The pancreas is a retroperitoneal organ located between the leaves of the mesocolon, in close proximity to the stomach, duodenum, transverse colon and spleen. In the presence of inflammation, and because of the structure's unique anatomic relation, the formative process tends to be localized. The products of inflammation, i., e., necrotic material and pancreatic juice, are encapsulated in a fibrous wall, with a resultant pseudocyst at the end of a one to three-week interval.

After the initial period of the formative process, the pseudocyst will develop anteriorly, in most cases being located in the lesser sac. Less common is anterior extension toward the gastrohepatic omentum, or within the leaves of the transverse mescolon. Rarely does the cyst extend behind the pancreas or into the posterior parietes.

The cyst usually is unilocular, and its contents will vary in quantity anywhere from three or four ounces to several liters. Boseman,[1] in 1881, excised a pseudocyst weighing 20½ pounds.

The character of the cyst content is variable and may be clear, serous, turbid or dark brown. Elements of blood degeneration commonly are present, a factor that determines the color of the cyst fluid. The fluid usually is rich in pancreatic enzymes.

Etiologic Factor

Acute or chronic, relapsing pancreatitis secondary to alcoholism or gallstones seems to be the most common etiologic factor of pancreatic pseudocyst, according to reported studies. Pancreatitis associated with cholelithiasis was also the etiologcial factor in one case in the present series.

Pancreatitis is reported as the etiologic factor in 65 to 75 per cent of cases of pancreatic pseudocyst and in only 10 per cent is the pseudocyst due to biliary pancreatitis. The next most common factor is trauma which, in most instances, is blunt in type. A classical example is the trauma of the steering wheel injury resulting from an automobile accident.

Biliary and gastric surgery are common causes of postoperative pancreatitis and pseudocyst formation. At other times, needle biopsy or direct operative trauma of the pancreas will result in the development of a pseudocyst.

Blunt trauma was the most common etiologic factor in our series of cases. In four cases of the seven, including two children, there was a history of trauma prior to onset of symptoms, the time interval ranging from three weeks to eight years. In one case, there was a history of penetrating abdominal injury, with pseudocyst formation 10 months later.

Neoplasm as an etiologic factor in pancreatic pseudocyst is rare. When existent, however, it usually is the result of coexistent inflammation frequently seen in carcinoma of the pancreas. In one of the reported cases, a neoplasm was suspected at the time of surgery, although a positive biopsy report was not obtained. Induration of the head of the pancreas, evidence of subacute pancreatitis and a pseudocyst of the pancreas were present. The preoperative and postoperative courses in this case confirmed existence of an underlying neoplasm. The patient expired five months after surgery, following progressive weight loss, recurrence of jaundice and wasting.

Clinical Features.—The statistical incidence of pancreatic pseudocyst in relation to sex shows wide variation, although male predominance is prevalent in most collected series of cases. Pseudocyst is extremely rare in children. In adults, traumatic origin is more common among those under age 35. When pancreatitis is the etiologic factor, the incidence parallels that of the underlying pancreatic disease, which is between the fourth and fifth decades.

Few patients remain asymytomatic after the cyst has developed. However, this was the case in one of those presently reported. The patient had sought medical attention because of varicosities of the chest wall secondary to a superior vena caval obstruction and, on examination, had been found to have an asymptomatic epigastric mass with a history of having been involved in a severe automobile accident eight years previously.

In most cases there is a history of alcoholism, or biliary tract disease, or trauma.

Signs and Symptoms

Pain is the most common symptom, and is located frequently in the epigastrium or in either hypocondrium, with occasional radiation to the back. Dyspepsia, nausea, vomiting and anorexia are also frequently present.

A palpable abdominal mass is observed in 75 per cent of cases. The mass usually is epigastric, with varying characteristics, depending on size, degree of surrounding inflammation, and length of time between formation and discovery. In most cases, the mass is smooth, unilocular and slightly movable, sometimes displacing with respiration.

In four cases in our series, there was a palpable mass of the epigastrium, and in one case the mass was located in the left upper quadrant.

Jaundice was noted in only one of our seven cases. It is present in 10 per cent of cases and in those of pseudocyst originating in the head of the pancreas.

There was high fever in three cases, two of whom were children. Less common findings are ascites, pleural effusion and diabetes.

Laboratory Findings.—The laboratory usually provides limited information in cases of pseudocyst. Elevation of the serum amylase has been found in a high percentage of cases. Glycosuria and hyperglycemia may be present, indicating extensive destruction of the pancreas by the underlying disease.

Radiologic Findings.—Direct x-ray of the abdomen will demonstrate a mass in rather a small number of cases, but barium studies of the GI tract may demonstrate displacement of the stomach, duodenum, or colon in a greater number. Of the seven cases is our series, there were suggestive x-ray findings in five.

Treatment

Surgical Management.—Treatment of pancreatic pseudocyst is surgical and should be applied in every case unless there is a major contraindication. Neglected cysts are prone to develop infection, intracystic hemorrhage, compression of the GI tract or biliary system, or spon-

taneous rupture in the peritoneal cavity—which, per se, carries a mortality rate of 53 per cent.

Basically, the applicable forms of surgical therapy fall in two categories: (1) excision and (2) drainage.

Type of Surgical Therapy.—In selecting the type of surgical therapy, several factors should be taken into account. Condition of patient, existence of underlying pancreatic disease, size of cyst, location of cyst, presence of surrounding inflammation, maturity of cyst wall—all are factors which would determine the appropriate procedure in each case.

1. Excision.
2. Drainage.
   - External—Simple catheter drainage.
     - Marsupialization.
   - Internal—Cystogastrostomy.
     - Cystoduodenostomy.
     - Cystojejunostomy.
     - Roux-en Y Cystojejunostomy.
     - Sphincterotomy. (Doubilet-Mulholland)

Excision was employed in one case in which there was a pseudocyst in the tail of the pancreas. The cyst was well encapsulated, with no connection to the surrounding viscera, presenting, therefore, the ideal situation for the type of therapy selected. Unfortunately, however, the ideal situation rarely presents itself.

With the use of excision, Warren, Marsh and Sandusky[10] report a surgical mortality of 12.5 per cent. Jordan and Howard,[6] in a collected series of 602 cases, report a mortality rate of 8.7 per cent. In the remaining cases, various drainage procedures were utilized. Marsupialization as a method of external drainage was first introduced by Gussenbauer,[4] in 1882. This method was chosen for treatment of a large pseudocyst in a two-year-old child whose general condition was precarious. The cyst was closely adherent to the liver and colon, and had a relatively soft wall. Postoperatively, the patient did well and there was no evidence of drainage two months after surgery.

Another accepted technique is simple catheter drainage, which can be done under local anesthesia if circumstances so require. The technique was employed in the case of a six-year-old child who presented with symptoms suggesting small bowel obstruction; the child was febrile and dehydrated. The postoperative course was un-

RESUME OF REPORTED CASES

AGE	SEX	ETIOLOGY	SYMPTOMS AND FINDINGS	X-RAY AND LAB FINDINGS	OPERATIVE FINDINGS	OPERATION
2 P.B.	F.	Trauma, blunt (3 weeks)	Elevated temperature, epigastric mass.	Epigastric mass displacing stomach and transverse colon compression of right ureter, hemoglobin 8 gm.	Large cystic lesion in lesser sac with adherence to liver & colon.	Marsupialization and catheter drainage.
6 R.B.	M.	Trauma, blunt (3 weeks)	Nausea, vomiting, fever, mid-epigastric pain, fullness in epigastrium.	Large mass with fluid, displacing stomach superiorly, anteriorly, dilatation of duodenum.	Large retroperiotoneal pseudocyst.	Catheter drainage.
24 F.B.	F.	Pancreatitis, Cholelithiasis, Previous sphincterotomy for pancreatitis.	Febrile, vomiting, chills, pain, epigastric mass.	Hemoglobin 9.7 gm. Cholelithias, large duodenal C loop.	Large cystic lesion base of mesocolon in body of pancreas.	Roux-en Y pancreatocystojejunostomy.
36 M.G.	F.	Trauma, blunt (8 years)	Asymptomatic. Superior vena caval obstruction, varicosities of chest & upper abdomen. Left upper quadrant mass.	Negative.	Cystic mass in tail of pancreas, varices in round ligament.	Excision.
34 E.L.	M.	Trauma, blunt (10 months) Explored.	Severe RUQ pain with radiation to back since one month after injury. Vomitus.	Negative.	Induration of head of pancreas, with a cystic mass.	T-tube choledocostomy; pancreatocystoduodenostomy.
45 W.S.	M.	Penetrating abdominal trauma. (2 years)	Abdominal pain, nausea, vomitus, abdominal distention, epigastric guarding.	Mass depressing colon.	Cystic mass in LUQ, body and tail of pancreas, extending in mesocolon; areas of recent pancreatitis.	Cystogastrostomy with transgastric tube drainage.
69 A.S.	M.	Pancreatitis secondary to cholelithiasis. ? Neoplasm.	Jaundice, acholia, anorexia, weight loss.	Large C loop of duodenum. T. bilirubin 18 direct 15; lap 442 B. S. 250 Sed. Rate 46 Alk. phos. 48.9	Cholelithiasis, obstruction common duct induration of head of pancreas & areas of recent inflammation. Pseudocyst of body of pancreas.	Cholecystoduodenostomy T-tube choledocostomy Cystogastrostomy Patient expired 5 months after surgery.

eventful, although drainage was somewhat excessive for several days immediately following surgery. The fistula closed spontaneously within six months, and the patient has been well ever since.

External drainage by either technique was the most commonly used type of treatment in the past, with a surgical mortality rate of 4.5 per cent, as reported by Howard and Jordan. As in the two cases just cited, this type of procedure may be used successfully in the case of the critically ill patient:

Complications commonly accompanying external drainage have been peritonitis, hemorrhage and development of a chronic fistula. In approximately five per cent of cases in which external drainage is used, it is necessary to perform additional surgery for treatment of the fistula.

Internal drainage was first used by Jedlicka[7] who, in 1923, successfully performed a cystogastrostomy. Several types of internal drainage technique are commonly employed, and the choice of treatment is based on the maturity of the cyst wall and its location, provided that the patient is a good operative risk. Mortality and therapeutic failures with use of this therapy have been low.

Because of the close adherence of the cyst to the posterior gastric wall, cystogastrostomy was used as the method of treatment in two of the seven cases comprising the series. Cystoduodenostomy was the method chosen for treatment in the case of a cyst located in the head of the pancreas, and a Roux-en Y Cystojejunostomy was used in the remainder of cases. Sphincterotomy, as proposed by Doubilet,[3] in combination with internal drainage, was not attempted in any of the seven cases.

There was no mortality and no instance of failure in any of the cases reviewed.

Summary

Surgical management of pseudocyst of the pancreas in a series of seven cases is reviewed. Various surgical approaches were employed, with satisfactory results. The morbidity and period of hospitalization were less in those cases in which treatment was by internal drainage methods. Patients in two of the seven cases were in the pediatric age group, in which the rarity of this lesion is even greater.

References

1. Boseman, N: Removal of Cyst of Pancreas Weighing 20½ Pounds, M. Rec. & Ann. 21:46, 1882.
2. Bockus, H. L.: Gastroenterology Philadelphia & London W. B. Saunders Company, 1965, Vol. III.
3. Doubilet, H. & Mulholland, J. H.: Pancreatic Cysts—Principles of Treatment, Surg. Gynec. & Obst. 96:683, 1953.
4. Gussenbauer, C.: Zur Operativen Behandlung der Pankreascysten, Arch. f. klin. Chir. 29:355, 1883.
5. Hillis, W.: Surgical Management of Pseudocyst of the Pancreas, Am. J. Surg. 105-651, 1963.
6. Howard J. M. & Jordan, G. L., Jr.: Surgical Diseases of the Pancreas, Philadelphia, J. B. Lippincott Co., 1960.
7. Jedlicka, R.: Eine neue Operationsmethode der Pankreascysten: Pancreatogastrostomie, Zentralbl. f. Chir. 50:132, 1923.
8. Miller, R. E.: Pancreatic Pseudocysts in Infants and Children, Arch. Surg. 89:517, 1964.
9. Kaiser, G. C., et al.: Pancreatic Pseudocysts, Arch. Surg. 89:275, 1964.
10. Warren, W. D., Marsh, W. H. & Sandusky, W. R.: Appraisal of Surgical Procedures for Pancreatic Pseudocyst, Ann. Surg. 147:903, 1958.

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Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

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Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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Sperling, I.L.: 3 Years' Experience with Oxyphenbutazone in the Treatment of Rheumatic Disorders. Applied Therapeutics 6:117, 1964.

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Watts, T.W., Jr.: Treatment of Rheumatoid Disorders with Oxyphenbutazone. Clin. Med. 73:65, 1966.

84.6% of 39 patients

Please see adjoining page for brief prescribing summary

TA-4919 PC

Emotional Illness and Problems of Adolescence*

Robert L. Vosburg, M. D.

ADOLESCENCE is worried over by sober judges, exploited by eager merchandisers and bemoaned by parents. It is a time of surging growth, great curiosity, skittish mood and strong rebellion. It is a time of Boy Scouts and gang warfare, of poetic yearnings and premature marriage. These yeasty years stand out in contrast to the relative calm of the latency child and the industrious young adult. Speaking of all adolescents, one is tempted to say that all are "sick," but to do this would be to involve ourselves in an apparent contradiction, that is, to be calling normative behavior "sickness." This contradiction is pursued in the following remarks:

Adolescent development is driven by hungers, curbed by obstacles, and helped and hindered by parents and peers. The physician glimpses these vicissitudes of growth and adaptation in terms of disease.

When an adolescent seeks us out, he may suffer from a single cause but his problem more often looks to us like a budget out of balance, the result of demands exceeding resources over a given period of time. Whenever a patient tells us of a "symptom," we view it as a ripple on the pond's surface, a report to us of disturbed equilibrium. For example, the conflict between forceful ideas may be manifest not only as subjective suffering but in such signs as blushing or acne. The way people talk about themselves and relate in a clinical interview enables us to assess these signs and symptoms and guess at their meaning. Subjectively, the sense of disease is much the same, whether the disturbing influence is, let us say, an adrenal tumor or a threatening father. The physician, a more objective observer, is able to relate the symptom to its cause.

Problems as Disease

This definition of disease, you will notice, states more precisely what is conveyed in everyday speech by the phrase, "He has problems." Quite properly, everyone at every age, no matter how neurotic or sick, encounters problems, solves them, and goes on to new situations. When we speak of the "emotional problems of adolescence" then, we refer to a special, recurring group of unsolved problems, characteristic of the age group between twelve and approximately twenty or thirty years. The lower age limit corresponds with sexual maturation, the upper with adult role assumption. The reason why these problems go unsolved generation after generation lies partially in the arrangement of American society.

The Author

- **Robert L. Vosburg, M. D., Professor and Chairman of the Department of Psychiatry, West Virginia University School of Medicine, Morgantown.**

Two Main Problems

Broadly conceived, the adolescent has two main problems: sex and work. If he can learn to love and to work, if he can acquire techniques for sustained heterosexual relations and productive labor, he will have attained maturity. Such a person is in balance with his community. Formerly, it was believed that the peculiarities of adolescence were attributable to the surge of growth and sexual maturation starting with puberty; but now we know that this belief was not correct. Margaret Mead traveled to Samoa and lived with the natives to test this hypothesis. She found that coming of age in that culture was a smooth process of transition from childhood to parenthood. This discovery resulted from applying the method called "the cross-cultural comparison." Similar studies reveal that adolescence is a time of great turmoil chiefly in the modern industrial societies such as the United States, Germany and Russia. This astonishing yet somehow-not-very-surprising discovery clearly indicates that neither political affiliations, religious beliefs, the lack of medical personnel, nor physiological maturation can be the single cause of the adolescent's turmoil. The answer partially is socio-economic.

Every industrial society requires long periods of training of its labor force. In everyday terms, the adolescent is rarin' to go but has no place to go and is unprepared to fill the spaces which are open. Centralized industrial operations take parents away from children so that opportunity for the child to identify with the parent and

*Presented before the Section on Neurology, Neurosurgery and Psychiatry, during the 99th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27, 1966.

Submitted to the Publication Committee, September 2, 1966.

gradually to assume an increasingly adult work role is lacking. At the psychological level, puritan ethics oppose easy sexual experimentation. At the physiological level, medicine has lengthened the average life span. Combine these factors with the age-old oedipal situation. The fastest way to success always has been to climb in a dead man's shoes. Today there are two applicants for every common labor job even though two spaces await every skilled worker.

In the past, various social institutions have evolved for handling the surge of youth. Some of these practices for maintaining the status quo look barbarous to us, such as that of castrating boys so that they could continue in their roles as sopranos in the choirs of the Church. Other solutions, for example, Hitler's organization of the youth of Germany, have resulted in the overthrow of the adult ruling group. In the United States, prolonged public education has evolved. It is, I believe, the best general solution of this particular problem that so far has come to light. Any educator must recognize that rebelliousness and competitiveness are "normal" feelings for adolescents, no matter how difficult such attitudes render our teaching.

Academic Freedom and Social Control

Academic freedom need not conflict with necessity for social control. Dictating dress or hair length is control but control of the wrong sort. The emphasis on early maturation frequently is irrational. For example, schools and colleges are criticized as "baby-sitting" institutions. Most adolescents, too, would be ashamed to hear this sobriquet applied to them. A more objective opinion is that dependant needs must be supported well into adult years. Unfortunately, the objective view is demeaned. It is demeaned because we harbor the notion that eighteen-year-olds should be adults, an expectation based on physiology and a farming-and-labor culture, but nevertheless unrealistic in the light of today's burgeoning technological society.

Conflicting Ideals

The subtle indoctrination of conflicting ideals goes on more or less unconsciously. The idea of advanced education is fine, but it has complications, and implications for emotional illness. Advanced education prolongs immature personality patterns and conflicts with sexual maturation. As Kinsey demonstrated by sex questionnaires (almost a generation ago—mores may have changed), the typical boy or girl who goes to college has had little or no coital experience by the time he matriculates, while the child who expects to go to work at the end of his high school course or to drop out, begins regular heterosexual experience during the junior high school years. Permission and instruction to follow one or the other of these two vastly divergent paths of sexual behavior come from the parents. Students who go on to attend graduate school are disciplined in absention to the extent of resemblance to priests and nuns. Indeed, the atmosphere of advanced study institutes invariably is monastic. Many times, the "kicks" and "joy rides" of adolescents represent attempts to get out of this straightjacket, "good education."

Reeducation Indicated

Although, as Freud suggests, the price of repression of aggression and sex may be neurosis, modern civilization has been bought in the bargain. Because of this compensation, psychiatrists seek to ameliorate repressive forces but do not necessarily seek to abolish them. Our job, generally speaking, is to work within the general rules for behavior of the culture but to reeducate people so that they suffer no more than necessary in gaining the fruits of adult civilized life. Such a course sometimes involves recommending greater freedoms, other times recommending tighter controls; we almost always urge adolescents to try to talk with their parents even if the parents seem to lie or to be evasive. An unsettled issue now facing adolescents and their parents is the ready availability of easy birth control measures. Parents and children alike will be doubly tempted toward sexual experimentation. It may be a blessing, not moral degradation; Margaret Mead points out that this development makes possible formalization of the trial marriage, just as a beginner now learns to drive an automobile on a learner's permit. The issue of birth control and population explosion is loaded in its entirety with misconceptions, bias and fear.* I do not know the answer to the population explosion, but I am confident that more practical education in sex would help out American marriages.

Cause of Problems

The causes of adolescent turmoil are not only physiological, related to growth, but also socioeconomic, i.e. related to finding a niche in our complex environment. One can single out misguiding parents, or industrial society, or mental retardation or sexual urges as "causes" but only at the price of over simplification. To be sure,

*For example, a medical authority was quoted in a national periodical as saying that only educated classes will use birth control, which will in time lead to a genetic preponderance of low-class people. This opinion, attributed to the Dean of the University of Michigan School of Medicine, is based on assumptions about the correspondence of good genes with middle- or upper-class income and education. It is a most unscientific utterance. As I understand the facts, the gene distribution in American society is more analogous to that of field mice rather than to selected strains of laboratory rats.

the boy with no job nor training and no prospects must steal or go hungry. The girl with no plans and naught but a pretty body will likely marry early and become depressed later. The sober facts show that the younger the couple at the age their first child is born, the more likely the family will live in poverty and the marriage end in divorce. At the same time physiological maturity appears to be attained earlier in all modern day societies. This long period between readiness and opportunity seems to be a basic, unsolved problem of our culture which influences all young people and their parents as well.

We're Self-Contradictory

At the same time, our daily behavior apparently works hard to maintain contradictory expectations. We promote sex, yet condemn it; we promote ambition, yet we say, "Keep out of my territory!" In this matrix of conflicting ideals our young people are expected to mature. Little wonder they're distressed.

Adolescent's Task Not Easy

As Erikson has written, the task of the adolescent is to find identity, to find who he is, where he is, what he can do, and what sexual gender he possesses in his relationship to other sexual working people. This is not an easy task. (cf. Erik Erikson, *Childhood and Society,* Norton, 1950.)

Will Find Way

To someone trained clinically to help individual patients, the overriding forces I have been enumerating seem staggering. Yet, all in all, our society seems to be faring pretty well. So, when I am confronted with the poignant urgency of the suffering adolescent's questions, I attempt to maintain optimism, i.e., the certainty that the voice of reason will win the day, despite the play of unreasonable forces that abound. Moreover, I am confident that the adolescent will be helped to find his way if given a map of the area he must traverse, but not necessarily one showing which route to travel.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

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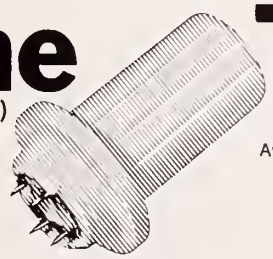

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Special Article

Medicare and the Nursing Home's New Image

John W. Cashman, M. D.

HOSPITALS, back in the 1800's and early 1900's, were often thought of as places where people went to die. In those days, because of limited medical knowledge, the mortality rate in hospitals was unbelievably high, compared with that of today.

In more recent years, nursing homes have fallen heir to the same sort of negative public image which formerly shrouded the hospital. Frequently, this image has been a true one. Many of us, from personal experience, could echo President Johnson's words: "I have seen nursing homes so shabby and so badly run that they make me heartsick and stomachsick, too."

On the other hand, there are many excellent nursing homes throughout the country, providing high quality patient care. These homes have been fighting an up-hill battle to combat the stigma which has often been unfairly cast upon them.

A Changing Public Image

Nursing homes across the nation are in the midst of a facelifting and a period of great expansion. Over half of all the skilled nursing home beds in the country have been provided in the past five years. The newer homes, generally speaking, are larger, furnished and equipped with more concern for the patient's care and comfort, and provide better and more comprehensive health services.

Much more remains to be done, however, and that is why President Johnson enlisted the support of a special task force to make plans for a truly modern program of nursing home construction. In his October 12, 1966, speech at Social Security headquarters in Baltimore, the President said that the goal of this program is to build nursing homes "especially designed for our older people so that they can live their lives in places of beauty and comfort."

An Intermediate Link

Medicare's program of "extended care"—around-the-clock skilled nursing care following a hospital stay—will give support to the national effort to accentuate the positive role of skilled nursing homes in medical care. The advent of extended care benefits last January 1 should do two things: (1) help dispel the long-standing view of the nursing home as the *final* link in the chain of health services for the elderly; and (2) help establish the nursing home as a vital *intermediate* link in the rehabilitative services to help the older patient get well.

For some Medicare patients, extended care in a Medicare-approved home will pick up where hospitalization leaves off. And, for many, extended care will be followed by part-time nursing and other health services in their own homes—also paid for by Medicare. In essence, this is progressive patient care in action—health services tailor-made to the patient's needs at each stage of his illness. Progressive patient care has long been espoused by physicians and health personnel. Because of the Medicare program, it can now be a reality for many more older Americans.

Many Kinds Of Care

There are, of course, many different *kinds* of nursing homes and many different *kinds of care* within the same nursing home. The various levels and types of care are reflected in the fact that nursing homes are also called rest homes, old folks' homes, homes for the aged, and sanitariums.

In addition, many hospitals have set aside special floors, wings, or wards which provide nursing care for persons with long-term illnesses. Frequently the patients are 65 and over. These special facilities within the hospital—often called "chronic care units"—function in much the same way as a skilled nursing home.

Now the Medicare program has come up with a new term—"extended care facility"—to denote

The Author

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Submitted to the Publication Committee, January 11, 1967.

a particular range of services provided according to specific requirements and standards. Any nursing home, home for the aged, or special part of a hospital can qualify to participate in Medicare as an approved "extended care facility" if it meets these requirements and standards.

What Is Extended Care?

An extended care facility under Medicare must be primarily engaged in providing round-the-clock skilled nursing care for its patients. It must have a transfer agreement with one or more participating hospitals for the appropriate transfer of patients. Each patient must be under the supervision of a physician; patterns of care provided to patients must be regularly reviewed by doctors and other health specialists through a "utilization review committee." In addition, every Medicare-approved extended care facility must admit patients and employ its medical staff without discrimination based on race, color, or national origin.

A hospital stay of at least three days is required before Medicare can pay for extended care. When the doctor determines that his patient no longer needs the intensive and more expensive hospital care (the cost per day in a hospital is usually more than twice that in a skilled nursing home), he can arrange for the patient's transfer to an extended care facility. This transfer has to take place within 14 days of discharge from the hospital. Also, the extended care must be for further treatment of a condition for which the patient was hospitalized.

Extended care, then, under the Medicare law, is a very special kind of nursing care. It is designed specifically for the person who has recently been in a hospital—who no longer needs the total range of hospital services, but still needs full-time nursing for a few more weeks or months.

What Extended Care Is Not

What extended care is *not*: it is not personal care for the relatively able-bodied in a residential old folks' home. It is not long-term custodial care for the infirm and chronically ill.

On January 1, 1967, Medicare *did not* start paying the bills for *all* patients age 65 and over who need 24-hour skilled nursing care. It *did* start paying, however, for the recently hospitalized older person, extended care benefits of up to 100 days in each "spell of illness"*—the full costs of covered services for the first 20 days and all but $5 a day for the next 80 days.

*A "spell of illness' begins when a person enters the hospital and ends after he has been out of the hospital (or nursing home) for 60 consecutive days.

Extended care benefits cover room and board in a semi-private room—a private room if it is medically necessary. Medicare pays for full-time nursing care; physical, occupational, or speech therapy; the services of a medical social worker; and for drugs, supplies, appliances, and equipment ordinarily furnished by the nursing home to its patients.

Getting ready for the start of extended care benefits on January 1, 1967, nursing home administrators have been working with social security and public health personnel to qualify for participation in the program. Of course, not all nursing homes were able to meet the standards or wanted to qualify as Medicare-approved extended care facilities; but enough homes participated so that many elderly people needing extended care will be able to receive it.

A Stimulus To Quality

The question has been asked, since extended care benefits under Medicare are intended only for the relatively short-term care of a recently-hospitalized patient, how can Medicare upgrade nursing home care in general? One way is through the requirement that the approved nursing home have a utilization review committee. The committee will regularly review the patterns of care for patients and help make sure that the home's services are being used in the most effective way.

In addition, the requirement that approved nursing homes have a transfer agreement with one or more hospitals will foster closer hospital-nursing home relationships. These closer ties may even include, in some cases, the sharing of professional personnel. Nursing homes may want to employ on a consultant or part-time basis, hospital-based pharmacists, medical social workers, dieticians, and physical, speech and occupational therapists. Moreover, extended care benefits include the services of interns and residents-in-training of a teaching hospital which has a transfer agreement with the nursing home.

Such a professional interchange cannot help but be mutually beneficial—hospitals will learn more about the special needs of the elderly patient and nursing homes will be able to draw upon the resources of the hospital.

When extended care benefits went into effect on January 1, 1967, a new stimulus for revamping the nursing home's image was set in motion. Not all nursing homes will be participating; not all nursing home patients will be eligible. The extended care benefits under medicare will represent a specialized type of after-hospital care

which only certain types of skilled nursing homes will be able to provide. Nevertheless, the extended care program will have a broad influence on nursing homes throughout the country. The long-term result should be to expand and upgrade the role of the nursing home in the community's total network of health services for all Americans.

European Postscripts

An impression obtained in England last year was brought home to the writer again this summer, so the initial observation must have been correct. The degree of Doctor of Medicine apparently carries with it little distinction in Great Britain today. The writer was on vacation, and admittedly did not emphasize that he was a physician, but whenever he signed a hotel register, this title was used. The desk clerk would scan the signature closely, and without exception would say, "Yes Mister so-and-so". All subsequent written or verbal communications were invariably initiated in the same manner. This also was true following introduction. A moment after the American would introduce himself as "Doctor", he would find himself addressed as "Mister". This was not due to the unflattering British custom of calling all surgeons "Mister", for the specialty of the writer was never mentioned. It is hard to escape the conviction that it indicated rather the low esteem in which the medical profession is held in the United Kingdom under the National Health Service.

A brief stay in the land of de Gaulle and the 40 (million) thieves brought a different set of impressions. The Paris edition of The New York Times seems to place a somewhat more liberal interpretation on the type of "news that's fit to print" than its American counterpart. The feature article on August 11 was Martin Tolchin's scoop concerning the self-limited population explosion that had just occurred in the New York area 270 days after the blackout last fall that plunged the city into darkness.

In some ways Paris has changed. One facility, notably absent today, was the quaint little comfort stations that seemed to dot every street corner 30 years ago. Only five were seen in two long pilgrimages about the city. They must have gone underground, perhaps as a result of the Occupation. The men who hawk the artistic postcards seem to have lost their old time verve too and appear more ready to accept the explanation that the hopeful purchaser is a physician.

The oddest item was saved for the moment of take off of the AIR FRANCE jet on the homebound flight. Some jokester with a wry sense of humor must have told the local music authorities that "Taps" was our national anthem or something closely akin to it. As the stairs were rolled away from the plane and the door was closed and secured the mournful bugle notes came over the public address system. They were loud and clear. The bugler seemed to linger over the last sad notes overly long and in the silence that followed one could almost hear the earth sifting down on the coffin. The Americans looked at each other in dismay and the plane took off. This was repeated in mid-ocean for the benefit of those who may have missed it the first time, and again as the plane came down through the fog to land at Dulles.

All of which reminds the writer of the familiar lyrical observation made a half-century ago—indeed, "the French they are a funny race."—H.J.W., in *Virginia Medical Monthly*.

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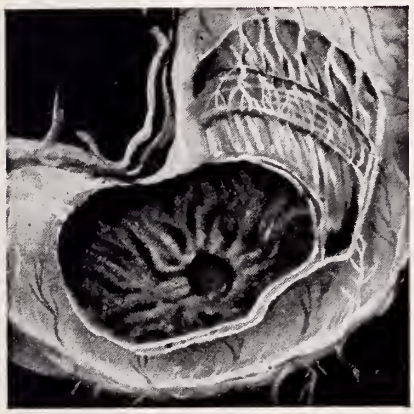

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A message from . . .

The President

MARCH WITH THE NURSES

THIS month of March has been set aside as "Nurses' Month" and in West Virginia, March 6-10 has been designated by the West Virginia Nurses Association as the days they celebrate for this National Event.

Congratulations to all the nurses on this occasion and inasmuch as this is the year of two centennials closely related—West Virginia State Medical Association and West Virginia University, this is also the 60th Anniversary of the West Virginia Nurses Association and a time for all-out celebration and congratulations.

In the year of the beginning of our Association—1867—a statement was made by Florence Nightingale that went like this: "No efficient, well-trained nurse would be likely to consider accepting a lower wage . . . Nurses must be paid the market price for their labor like any other workers and this is yearly rising." I'm sure that same Florence Nightingale stood up and cheered over the events of the past few months concerning wages!!!

The medical profession has been and is in sympathy with the wage increase demands and I feel sure we will cooperate in helping to settle any difficulties in an amicable manner.

Belatedly many thanks to Dwight Cruikshank, Dick Corbitt and to all the Parkersburg Academy of Medicine for their kind reception of me as President of our Association; an apology to West Virginia University Medical School and Dean Sleeth and the Monongalia County Medical Society for the weather snowing me under and I'm looking forward to another date being set for my visit.

Attended the Socio-Economic Conference and the Medical Education Conference in Chicago—seems to me that the time has come for us to send more "stuff" nationally than for the AMA to be sending "stuff" to us. More about that at a more appropriate time.

At this writing, plans are being formulated for "the call" meeting commemoration of our founding in Wheeling on 28 February 1967—after that for a celebration in Fairmont on 10 April 1967. EVERYONE PLEASE try to save time around the 10 April 1967 for this celebration . . . I'd like to see EVERYONE there—after that we'll work specifically on the August meeting!!!

Again, congratulation to the NURSES, and again, try to come to our Centennial Celebration in Fairmont on 10 April, 1967—a good celebration is being planned by Tom Evans, et al and thanks to them and all others I should have been thanking and haven't done so lately.

And, a Happy, Happy Easter to all.

RICHARD E. FLOOD, M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

GRADUATE MEDICAL EDUCATION—1967

There has just come to hand a copy of the Millis report on graduate medical education. The Commission, appointed by the Board of Trustees of the AMA, has apparently made certain recommendations based upon the premise that changes in graduate medical education are essential, and that if organized medicine does not accept the responsibility for effecting same, the federal government, acting on behalf of an aroused and demanding public, will step into the alleged vacuum and assume the responsibility of amending our graduate medical programs.

The report first recommends the abandonment of our present internship training and combining this year with our present residency training, thus forming a single period of graduate medical education. State licensure and certification would then be given only upon completion of an appropriately described period of graduate medical education. The specialty board's regulations would be amended so as not to increase the required length of residency training as a means of compensating for the loss of the intern year.

The hospitals would be required to experiment and rearrange the several forms of residency training. The approval for such new programs would be determined by residency review committees. A new Commission on Graduate Medical Education would have the responsibility of planning, coordinating and reviewing these educational standards.

All this is in the stated interest of providing comprehensive health care by an increasing number of general practitioners, who by their basic resident's training, would be professionally competent to assume many of the responsibilities and prerogatives now covered by the mantle of specialization. As we see it, the age of the certified generalist is at hand. This comprehensively trained young men of medicine would be educated to perform many of the more simple operative, diagnostic and therapeutic procedures now assumed by a board certified specialist. Insofar as these responsibilities are now accepted by many general practitioners in varying fields from surgery to obstetrics, the additional required training would be of distinct value. One can visualize the growing content of members of the American Academy of General Practice and the increasing discontent of many of those certified by the various specialty boards.

The progress of this recommended change in medical education will be of interest to the observer and of concern to those involved. As our world changes, natural attrition will soon eliminate the old family physician and in his place will develop the bright young man who can do

a simple appendectomy, a tonsillectomy, a cystoscopy, or apply high forceps but who will stand clear from gastric resection, nephrectomy or open heart surgery.

Now if some Commission would but come up with a simple means of determining where the generalist leaves off and the board specialist takes over, then indeed will occur another milennium in the affairs of the Great Society.

Selah!

MORE MEDICARE

In this issue of *The Journal* there is a special article on "Medicare and the Nursing Home," that may resolve some of our misunderstanding in this field of medicine. Extended care is an important link between hospital service and complete well being. It is designed to relieve the hospital load, also the effort and anxiety of Utilization Review Committees. It provides 24-hour nursing and medical care in a special facility, which may be a part of the hospital complex or may be a separate establishment Perhaps convalescent home is a better understood term for this halfway house.

Physicians are loath to read the mass of articles, pamphlets and books concerning the ramifications of Medicare, but this article does deal with a big business in a brief and pointed manner. Again patients will learn that another of the diversified services of Medicare is not exactly free of charge, but necessitates some financial participation on their part. Here also, the Utilization Review Committee can determine the duration of stay and treatment. Such committees may be composed in large part, of lay members, so here is an unpaid time-taking activity that the doctor may escape if he chooses to leave his problems to non-professional people.

Few nursing homes in West Virginia qualify under present rigid standards. This does not indicate that the unqualified home does not adequately meet the purpose for which it was created. Many of our aged can do with less service than the extended care unit requires. Many nursing homes will not care to be concerned with the multiplicity of details required for certification. Such homes can continue to give sufficient custodial and medical care to cope with our present social needs.

Another aspect of Medicare coming forcibly to our attention is "Home Health Services." The amount of Home Care now depends on the availability of these services which are distributed by the local intermediary, usually the county health department. Many counties now have skilled nursing service available, and some have physical therapy. This department of Home Services can be expanded to include speech therapy, occupational therapy, special aides, social services and all manner of personal services. All such care and services must be prescribed by the attending physician, and this should be done with detail and precision. The paper work increases with the services, but your local purveyor can minimize this burden with your cooperation.

Physicians can be expected to utilize these services as they become available, providing doctors are made aware of such services. It is doubtful if these services will be prescribed to an extent that will satisfy all the eager beavers operating the service. It does seem that many persons in this division of Medicare are working under Parkinson's Law.

Every patient over 65 does not require a Swedish massage or physical therapy. Millions of people have learned to live with chronic ailments and can administer to all their home needs, sometimes with familial assistance. The treatment of diabetes mellitus exemplifies the magnificent manner in which a million individuals have been taught and trained to care for a devastating chronic illness through their own resources. The usual quiet consultation between the hospital patient and his physician, with direct instruction for home treatment, will continue to be a more important service to the patient than multiphasic visitation. Doctors should ascertain the services that are available in their area and utilize them with judicious discrimination.

RETURN YOUR QUESTIONNAIRE

A questionnaire prepared by our Committee on Medical Education and Hospitals should have reached the desk of every member of the Association on or about February 11.

Four days later, more than one-third of our members had filled out the questionnaire and returned it to the Headquarters Office. Madison Avenue would probably call this a colossal response, and indeed it is.

Most of our readers are aware of the plans of Dr. Pat A. Tuckwiller's Committee to institute a coordinated program of postgraduate education for physicians of our State. The fine physicians who serve on this Committee are hopeful that information obtained through this questionnaire will steer them to the proper course.

We salute Doctor Tuckwiller and his Committee, and we urge physicians who have not as yet done so to take a few minutes to complete the questionnaire and return it in the accompanying envelope.

GENERAL NEWS

Dr. Milford O. Rouse Honor Guest At Centennial Meeting

Dr. Milford O. Rouse of Dallas, Texas, President Elect of the American Medical Association, will be a guest of honor at the 100th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 24-26.

Milford O. Rouse, M. D.

Dr. Ray S. Greco of Weirton, Chairman of the Program Committee, said Doctor Rouse has accepted an invitation to speak at the first session of the House of Delegates on Wednesday afternoon, August 23. It also is hoped that Doctor Rouse will find it possible to attend other functions in connection with the meeting which will be the official observance of the 100th Anniversary of the founding of the Association.

A native of Jacksonville, Texas, Doctor Rouse will be installed as President of the AMA next June in Atlantic City. He served for three years as Speaker of the House of Delegates and, prior to that, had been Vice Speaker of the House for four years. He was named President Elect during the AMA meeting in Chicago last June.

His parents were Southern Baptist missionaries and he spent part of his boyhood in Brazil. He was graduated from Baylor University and received his M. D. degree in 1927 from Baylor University College of Medicine. He interned at Fort Sam Houston Station Hospital, 1927-28.

Doctor Rouse has practiced in Dallas since 1928, specializing in gastroenterology. Since 1943, Doctor Rouse has been Clinical Professor of Medicine at the University of Texas Southwestern Medical School and he previously taught at the Baylor University College of Medicine when that school was located in Dallas.

Doctor Rouse has contributed more than a score of papers to journals throughout the country. He is a Past President of the Dallas Southern Clinical Society, the Texas Medical Association and the Southern Medical Association. He is a Diplomate of the American Board of Internal Medicine and a Fellow of the American College of Physicians.

He was married in 1927 to the former Leaureame McDavid, and they have one daughter and three grandchildren.

Special Events Planned

The Program Committee has been at work since last September making arrangements for the Centennial meeting. Several special events are being arranged for the meeting and further details will be announced in future issues of *The Journal*.

General scientific sessions will be held on Thursday, Friday and Saturday mornings, August 24-26. Sections and affiliated societies will meet during the afternoon hours.

Serving with Doctor Greco on the Program Committee are Drs. Richard W. Corbitt of Parkersburg, Robert Greco of Morgantown and Joseph D. Romino of Fairmont.

House to Meet Twice

The House of Delegates will meet twice during the Centennial meeting. The first session will be held on Wednesday afternoon, August 23, and the final session on Saturday afternoon, August 26.

The pre-convention meeting of the Council will be held on Wednesday morning.

State Health Conference in May

The West Viginia Public Health Association will sponsor its Annual State Health Conference at The Daniel Boone Hotel in Charleston, May 11-12.

W. Va. Acad. of Oph.-Otol. Lists Spring Program

The West Virginia Academy of Ophthalmology and Otolaryngology has announced the complete program for its 20th Annual Spring Meeting, which will be held at The Greenbrier in White Sulphur Springs, April 23-26.

Howard P. House, M. D.

Alson E. Braley, M. D.

About 400 physicians and guests are expected to attend the sessions, which will feature four speakers on ophthalmology and four on otolaryngology. A registration fee of $35 for non-members covers the scientific sessions and social occasions.

The following papers on ophthalmology will be presented:

"Best's Disease or Vitelliform Macular Degeneration and Some Other Familial Macular Changes" and "Treatment of Blepharitis and Keratitis"—Alson E. Braley, M.D., Iowa City, Iowa.

"The Diagnostic Uses of Ultra Sound in Clinical Ophthalmology" and "Ocular Trauma Prevention and Salvage"—Arthur Keeney, M.D., Philadelphia, Pennsylvania.

"Comparison of Photocoagulation, Diathermy and Cryothermy for Retinal Detachment Surgery" and "Developments in Retinal Detachment Surgery"—Donald M. Shafer, M.D., New York City.

"The Repair of Defects of the Lid and Lid Margin" and "The Assurance of Uncomplicated Cataract Extraction"—Joseph A. C. Wadsworth, M.D., Durham, North Carolina.

The following papers on Otolaryngology will be presented:

"Causes of Failure in Stapes Surgery" and "Panel on 'Otologic Surgical Problems'"—Howard P. House, M.D., Los Angeles, California.

"The Role of Nystagmography in Clinical Vestibular Evaluations" and "The Technique of Nystagmography-Simplified Clinical Approach"—Wallace Rubin, M.D., New Orleans, Louisiana.

"The Confused Problem of Sinus Disease" and "The Management of Chronic Infectious Sinusitis"—Sam Sanders, M.D., Memphis, Tennessee.

"The Significance of A Little Lump in the Neck'" and "The Composite Operation for Control and Cure of Intraoral Cancer"—George A. Sisson, M.D., Syracuse, New York.

Copies of the program and other information may be obtained by writing to Dr. J. Elliott Blaydes, Jr., Secretary-Treasurer, 107 Federal Street, Bluefield.

Am. Col. of Physicians Lists PG Courses

The American College of Physicians will conduct seven postgraduate courses during March and May. The schedule is as follows:

March 6-10—"Recent Advances in Cardiovascular Disease," New York City.

March 13-17—"Physiological Aspects of Cardiopulmonary Disease," New Haven, Connecticut.

March 20-24—"Fundamental Concepts of Gastroenterology," Ann Arbor, Michigan.

March 27-31—"Psychiatry for the Internist," Detroit, Michigan.

May 8-12—"Clinical Auscultation of the Heart," Washington, D. C.

May 15-19—"Recent Advances in Clinical Endocrinology," Seattle, Washington.

May 22-26—"Clinical Applications of Recent Advances in Electrophysiology of the Heart," New York City.

Tuition fees are $60 for ACP members and $100 for nonmembers. Additional information may be obtained by writing to Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

AAPS Meeting In Chicago

The House of Delegates of the Association of American Physicians and Surgeons will have an Interim Meeting in Chicago, April 7-8.

Dr. Curtis W. Caine, the Speaker, will preside over House sessions on Friday morning, April 7, and Saturday morning, April 8. Afternoons will be devoted to committee meetings and other activities.

The reception and banquet will be held on Friday evening, with the President, Dr. James A. Cosgriff, presiding. The speaker for the banquet will be Dr. Edward R. Annis of Miami, Florida, a Past President of the American Medical Association.

Cleveland Clinic Lists PG Courses

The Cleveland Clinic Educational Foundation will sponsor five postgraduate courses during March and April.

They will be the final courses of the Foundation's 1966-67 program.

The dates and topics are as follows:

March 8-9—"Advances in Urology."

March 15-16—"Postgraduate Course in Anesthesiology."

March 29-30—"Medical Progress and Its Relationship to Dentistry."

April 5-6—"Diagnostic Procedures in Gastroenterology."

April 26-27—"Diabetes Mellitus: The Old and the New."

Maryland Medical Lists Annual Meeting

The 169th Annual Meeting of the Medical and Chirurgical Faculty of Maryland will be held at The Alcazar in Baltimore, April 19-21.

Among the speakers will be Dr. Milford O. Rouse, President Elect of the American Medical Association. Doctor Rouse will speak on Thursday, April 20, on "Partnerships in Peptic Ulcer."

The Faculty's House of Delegates will meet on Wednesday, April 19, and Friday, April 21. The Annual Reception and Presidential Dinner will be held on April 20 at the Sheraton-Belvedere Hotel.

There is no registration fee, and credit will be allowed by the American Academy of General Practice.

A detailed program may be obtained by writing to Dr. James B. Brooks, Chairman, Committee on Program and Arrangements, 1211 Cathedral Street, Baltimore, Maryland 21201.

Heart Association Sets Deadline For Paper Abstracts

The American Heart Association has set May 15 as the deadline for submitting abstracts of papers to be considered for presentation at the 1967 Scientific Sessions in San Francisco, October 20-22.

Papers should be based on original investigations in the cardiovascular or related fields. Abstracts, briefly digesting results obtained and conclusions reached, are limited to 250 words.

Forms for submitting abstracts and applications for exhibit space may be obtained from the West Virginia Heart Association, 759 West Washington Street, Charleston, West Virginia 25302.

College of Physicians Admits Five W. Va. Physicians

Five West Virginia physicians were elected to membership in the American College of Physicians on November 12, 1966.

Elected Fellows of the ACP were Drs. David Z. Morgan and John E. Jones, both of Morgantown; and Dr. Harold Selinger of Charleston. Doctor Morgan is Assistant Dean of the West Virginia University School of Medicine.

New Associates of the ACP include Drs. German Lizarralde of Morgantown and William C. Revercomb, Jr., of Charleston.

Gov. Smith Names Dr. Ashworth To Health Board

Gov. Hulett C. Smith has appointed Dr. Harold B. Ashworth of Moundsville to the State Board of Health for an unexpired term ending June 30, 1974.

Doctor Ashworth succeeds Dr. D. A. MacGregor of Wheeling, who resigned. The appointment was effective February 3.

A native of McDowell County, Doctor Ashworth attended West Virginia University and received his M.D. degree in 1930 from the Medical College of Virginia. He was an intern at Youngstown City Hospital in Ohio, 1930-31.

Doctor Ashworth is a member of the Marshall County Medical Society, the West Virginia State Medical Association, the American Medical Association and the American Academy of General Practice. He is a former President of the Marshall County Medical Society.

From 1942 to 1945, he served in the Medical Corps of the Armed Forces.

The Kanawha Medical Society installed its new officers at the annual dinner dance at the Daniel Boone Hotel in Charleston on January 14. In left picture, Dr. Edward Jackson of St. Albans (left) congratulates the new President, Dr. Joseph A. Smith of Dunbar. In picture at right, Doctor Smith is shown with the new Vice President, Dr. E. Q. Hull, and Mrs. Smith (left) and Mrs. Hull (right). Dr. George R. Callender, Jr., of Charleston is the retiring President of the Society.

The Medical Society of West Virginia

(A Second Look at Its Beginning)

In *The West Virginia Medical Journal* of November, 1966, we published the contents of the original Circular of January 19, 1867. At that time publication date was given as February 28, 1867, but the date on which the Circular was developed was the earlier one, or January 19, 1867.

The Circular was addressed "To the Medical Profession in West Virginia," and stated, "Those receiving this Circular will please consider it as a personal invitation to attend the proposed convention." Thereafter was the Circular as previously reported.

On March 1, 1867, the Wheeling Intelligencer reported as follows:

> MEDICAL: We understand that an informal meeting of physicians took place in the Parlor of the McLure House Wednesday evening looking toward the establishment of a State Medical Society. Dr. Bates was called to the Chair, and Dr. Reeves of Fairmont was appointed Secretary. A harmonious interchange of opinion was had and on the motion of Dr. Hildreth, Drs. Reeves and Hupp were appointed a Committee to prepare a suitable call for a Convention to meet in Fairmont on the 10th day of April next. This call will appear in circular form and will be sent to physicians in all Counties of the State. All will agree that this is a work in the right direction.

The Journal is indebted to Dr. James Cummins Hazlett of Wheeling, West Virginia, for the following communication concerning the Circular:

"This was presented to the undersigned by our longtime family physician, Dr. Andrew Wilson, prior to his death, with the following instructions:

"'Jim, keep this in trust; I present it to you because I know you have the interest and historical connections to preserve it. If and when the Ohio County Medical Society has a permanent home, you are to present it to our Society; for it really belongs to them; should we never have a permanent home in your lifetime, pass it on to another with your same interest in preserving a part of our heritage.'

"Dr. Andrew Wilson had received this document from his older half-brother, Dr. Lew Delaplane Wilson (who had also been our family physician before his death).

"The notation at the end of the Circular, on a separate piece of brown paper, was in the handwriting of Dr. L. D. Wilson—the very last line, however was written by Dr. Andrew Wilson.

"The entire Circular is written on a piece of paper 5 inches wide and 22 inches long. The initial statement regarding the invitational status of the Circular is also on a separate piece of paper. That this was rather hurriedly written is attested by the fact that there are several words crossed out, the word "And" beginning line 14 of page two; an undecipherable word (the second in line 15, page two); and the reduplicated word "meet" in the fifth line from the bottom on page two.

"The M. D. following the names of H. W. Brock and John C. Hupp are crossed out; why is unknown, because both were Doctors of Medicine, and entitled to the degree. Ditto marks follow the other names on the list. Dr. George A. Cracraft was the father of Dr. Will Cracraft, who practiced in Wheeling for many years, and who died several years after I entered practice in Wheeling. Drs. Hildreth, Hupp, Todd, Bates and Frissell were prominent physicians in Wheeling, and I have heard my parents speak of personal knowledge of all of them. Dr. R. H. Cummins (Robert Hazlett Cummins) was my maternal great grandfather, and James Cummins was his brother. Dr. R. H. Cummins was afterwards President of the West Virginia Medical Society, in 1873, his death occuring prior to the Annual Meeting, his President's Address being delivered by Dr. E. A. Hildreth, at Dr. Cummin's request.

"In addition to Dr. Cummins, the following were Presidents of the State Society:

W. J. Bates	1867
John Frissell	1868
H. W. Brock	1869
J. W. Ramsey	1870
E. A. Hildreth	1877
J. E. Reeves	1882

"In the original, the date was first April 20th, but this has been scratched out, and March was substituted."

———

"I hope we shall all feel a pride in so conducting the affairs of this society, and after a half century has passed by, and the profession of a new generation occupy our places, as they look over the books and musty pamphlets of olden time, and read the records and early history of this society, they will all be constrained to say that the founders of the Medical Society of West Virginia were wise and good men; that they inculcated sound doctrines in medicine and morals, and deserve to be remembered among the benefactors of the human family."

At the Golden Anniversary the meeting of the House of Delegates found the reports of committees woeful due to the lack of completion or absence of members.

The Secretary in 1917 reported there were 852 dues-paying members and 902 certified members. The Secretary complained of the lack of information concerning the doings of the component societies.

The publication committee requested more information about county activities, more news and more manuscripts. The membership was admonished to purchase supplies only through *Journal* advertisers and to make every effort to promote state and local advertising. For 1916 *The Journal* showed a surplus of $534. This was a welcome increment to the treasury; however, there was a hooker in the report. The Editor was paid $900 a year from the general treasury. To this historian it seems this was a lovely little custom and further research may indicate when and why this was abandoned.

The scientific essays were excellent. Many speakers were out-of-state authorities.

At the semi-centennial convention in Fairmont on October 1, 1917, Dr. E. J. Rader gave some historical highlights of the Association in his presidential address:

"Important as any meeting of the West Virginia Medical Association should be, and is, we are reminded at this time that this is an extraordinary meeting, from the fact that we celebrate our golden jubilee; the semi-centennial meeting of our association, which fifty years ago twenty-two physicians representing ten counties of our state met in this busy mountain city, nestling here among the beautiful hills of our Little Mountain State overlooking the placid waters of the Monongalia, and organized what is now known as the West Virginia State Medical Association. That little craft which was hewn out at Fairmont, and cut loose from that quiet mooring on the tenth day of April, 1867, with less than twenty-five passengers on board has increased her number of passengers until today she carries over nine hundred and there is room for many more. She has again been borne to this hospitable port by pleasant breezes, where she completes her fiftieth annual voyage, and cast anchor for a few days in the city of her birth in order to give an account of her stewardship and obtain a renewal of supplies."

Quoting from Dr. James E. Reeves, Chairman of the Committee on Arrangements in 1867, President Rader said, "You come to lay the foundation of a State Medical Edifice, whose grand superstructure, though not to be made of granite and marble, will be none the less enduring, and none the less honorable to the profession and to West Virginia."

Only one of the charter members, Dr. J. H. Brownfield of Fairmont, attended the 50-year anniversary. He was the only living charter member.

Doctor Rader stated on February 28, 1867, 16 physicians, eight of them from Ohio County, met at the McClure Hotel and issued the original Circular with which we hope you are familiar.

Doctor Frissell, of Ohio County, President of the Medical Society of West Virginia, closed his address in October 1867, with his hope for the future of the society.

(TO BE CONTINUED)

Emphysema Is Growing Health Threat

State Health Director N. H. Dyer named emphysema, a disease of the lungs, as a growing threat to our State in a recent issue of the "State of the State's Health."

In 1955, West Virginia reported 45 deaths from emphysema. "Within 10 years that figure has climbed to 224," the health official remarked. He reported that national deaths from emphysema in 1963 were nearly six times the number in 1953. "Even these figures most likely do not reflect the true extent of the disease," Doctor Dyer said.

Doctor Dyer said it had been estimated that from one to 10 million Americans are afflicted to some degree by emphysema. It is more widespread than lung cancer and tuberculosis combined, and almost as prevalent as arthritis, he commented.

Doctor Dyer pointed out that emphysema can no longer be regarded as strictly a male disease. He said that the increase in death for both sexes had been remarkably parallel over the last few years. According to the U. S. Public Health Service, the number of women dying from emphysema and chronic bronchitis has quadrupled during the last 10 years.

Emphysema is an irreversible disease that causes a progressive breakdown of the air sacs in the lungs and produces a shortness of breath and can end in suffocation, Doctor Dyer explained. The destruction of the alveolar walls and their supporting structures results in air-trapping. The lungs lose their elasticity, become flabby and are continually overinflated. Thus, he observed, an emphysema patient's lungs are half filled with stagnant air, causing him to breathe twice as much to get the same amount of air.

The causes of emphysema are still unknown, Doctor Dyer stated, but certain factors are suspect. Exposure to lung irritants, disease-producing organisms, polluted air, cigarette smoke, and allergic materials are thought to contribute to the development of emphysema, he said.

Studies have shown that emphysema is about 13 times more prevalent among cigarette smokers than among non-smokers and that most sufferers are men over 40 years of age who are cigarette smokers, Doctor Dyer added. According to the U. S. Public Health Service, not less than 10 per cent of middle-aged and elderly Americans are probably afflicted.

"If pulmonary emphysema is diagnosed early enough," the health official stated, "it can be brought under almost complete control even though previous lung damage is permanent. But all too often the disease does not become symptomatic until years after its onset. By the time a patient becomes aware of his shortness of breath and fatigability, he may already have lost over 50 per cent of his lung function."

Doctor Dyer concluded that emphysema is somewhat difficult to detect since a person is very likely to brush off telltale signs of the disease such as cough, shortness of breath, and chronic tiredness as attributable to other factors.

In another issue of the "State of the State's Health," Doctor Dyer discussed the Medical Self-Help training course available through the local health departments and Civil Defense Offices. He explained the purpose of the 16-hour course was to train laymen to administer emergency medical care in the absence of medical personnel.

"The national goal and the objective of our state is to have at least one person in every family trained in Medical Self-Help," Doctor Dyer said. "This means about 200,000 West Virginians need to be trained. At present, we have not trained one per cent of this figure over a period of five years."

Doctor Dyer explained that every community should promote a program to encourage the participation of its citizens in one of the training programs. He said the course is conducted without charge and student materials, training kits, and a "Family Guide Emergency Health Care" reference are furnished.

The Division of Health Mobilization, in a recent report, indicates that 44.6 per cent of the instructors are school teachers, 12.2 are nurses, 7.9 are professional and technical (non-medical including military officers), 5.1 are allied health workers, and 1.8 are physicians, Doctor Dyer reported.

The agencies sponsoring the course are schools 44.4 per cent, Civil Defense 17.5, health departments 15.8, other government agencies 12.4, Red Cross 3.4, and miscellaneous agencies, including medical and dental societies, 6.7 per cent, he said.

West Virginia ranks 41st in the nation with the number of people trained in Medical Self-Help since 1963, Doctor Dyer reported. It ranks 48th for the 1967 fiscal year with only 15 or 27.3 per cent of the counties reporting classes. The health official urged West Virginians to take the course and be prepared to save a life.

Heart Fund Grant Requests Due By April 1

The West Virginia Heart Association has set April 1 as the deadline for receiving applications for research grants-in-aid from investigators in West Virginia working in the cardiovascular field.

Grants are not restricted to any particular discipline, but the investigator must be qualified and have facilities available to pursue his work. Although no maximum grant has been established, individual requests should not exceed $3,000.

Grants are awarded by the West Virginia Heart Association to scientists who need interim or supplementary support for on-going projects or who wish to demonstrate by pilot experiments the value of a new project. The program is separate from that of the American Heart Association.

Applications and additional information may be obtained by writing to: Mr. O. D. Wyatt, Executive Director, West Virginia Heart Association, 759 West Washington Street, Charleston, West Virginia 25302.

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association and Mrs. Ilu C. Myers of Philippi, President of the Woman's Auxiliary to the Association, were guests of honor at a dinner dance conducted by the Parkersburg Academy of Medicine in Parkersburg on January 12. Shown in the picture from left to right are: Dr. Robert D. Crooks, Secretary-Treasurer of the Academy; Dr. Delmer J. Brown, President Elect; Dr. Dwight P. Cruikshank, President; Doctor Flood; Mrs. Myers; Dr. Richard W. Corbitt, who arranged the evening's program; and Mrs. Donald R. Lantz, President of the Woman's Auxiliary to the Academy.

These four veteran physicians were honored on January 12 by the Parkersburg Academy of Medicine for their long dedicated service to medicine. From left to right are: Dr. Orva Conley of Parkersburg, Dr. R. C. Newman of Spencer, Dr. S. M. Prunty of Parkersburg and Dr. Russell H. Paden of Parkersburg. Each was presented a plaque in recognition of at least 50 years of service. Four other members of the Academy were similarly honored but were unable to be present for the ceremony. They are Drs. Ralph H. Boice of Parkersburg, Thomas L. Harris of Parkersburg, Eugene Hartman of Parkersburg and Paul C. Starkey of Ravenswood.

PG Course in Philadelphia

A course in "Clinical Electroencephalography" will be conducted in Philadelphia, June 5-7, 1967.

This is the second course sponsored by the American EEG Society under a grant from the Bureau of State Services, U.S. Public Health Service. It is designed for physicians who have had little or no formal EEG training.

Other details may be obtained by writing to Dr. Donald W. Klass, EEG Course Director, Mayo Clinic, Rochester, Minnesota.

Diabetes Book for Laymen Is Available

The Diabetes Press of America in Miami, Florida, is accepting orders for a book entitled "Diabetes for Diabetics", which was written by Dr. George F. Schmitt of Miami.

The 230-page book has 212 full color illustrations. It covers the fundamentals of diabetes, diet, insulin, oral anti-diabetic drugs, urine testing, hygiene, complications, special problems and special subjects and also contains a glossary and index.

Doctor Schmitt has directed the text toward laymen. He is a graduate of the University of Maryland School of Medicine and also is a graduate pharmacist. He is a Fellow of the American College of Physicians and is certified by the American Board of Internal Medicine.

According to the Dade County (Florida) Medical Association, the profits of the Diabetes Press go for camp scholarships for diabetic children.

The book may be ordered at $5.95 per copy from The Diabetes Press of America, Inc., 30 S. E. Eighth Street, Miami, Florida 33131. A folder describing the book also is available from the publisher.

American Rheumatism Assn. Meeting in New York

The annual meeting of the American Rheumatism Association will be held in New York City, June 15-16.

Sixty-five papers on recent developments in arthritis and rheumatism research will be presented. The Paramedical Section will hold its second annual scientific sessions on June 16.

Additional information may be obtained by writing to Miss Margaret M. Walsh, 1212 Avenue of the Americas, New York City, New York 10036.

ACP Meets in San Francisco April 10-14

The 48th Annual Meeting of the American College of Physicians will be held in San Francisco, April 10-14.

In addition to the scientific program, several social and other activities have been arranged. These include a concert by the San Francisco Symphony Orchestra, the President's Reception and Dinner-Dance and the Annual Convocation, when new Fellows of the College will be inducted.

There will also be a program for wives of participants in the Annual Meeting.

The Committee on Nominations of the ACP has nominated a slate of officers for 1967. The election will take place on April 13.

Dr. H. Marvin Pollard of Ann Arbor, Michigan, was nominated by the Committee for the office of President Elect. The Committee also nominated Drs. Samuel P. Asper, Jr., of Baltimore, Stacy R. Mettier of San Francisco, and Victor Grover of Springfield, Massachusetts, for three vice presidencies. Other nominations may be made from the floor.

The ACP will sponsor two tours after the convention. One is a tour to Hawaii, April 15-22, and the other is a tour to the Orient, April 22-May 12. Visits to foreign medical centers are being planned in conjunction with the tours.

Additional information about the meeting may be obtained by writing to Dr. Edward C. Rosenow, Executive Director, the American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Two other activities of note will be conducted April 7-9, prior to the opening of the convention.

One is the annual meeting of the American Society of Internal Medicine. Information may be obtained by contacting Mr. Albert V. Whitehall, Executive Director, American Society of Internal Medicine, 3410 Geary Boulevard, San Francisco, California 94118.

The other pre-convention activity is a postgraduate course on operable heart disease sponsored by the American College of Cardiology. Information may be obtained from Mr. William D. Nelligan, Executive Director, American College of Cardiology, 9650 Rockville Pike, Washington, D. C. 20014.

Radiology Group Admits Doctor Curry

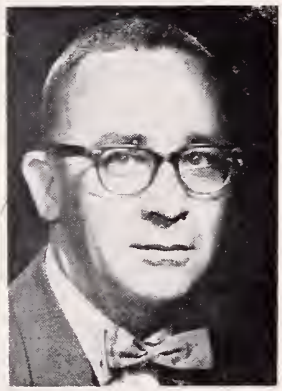
Dr. Joseph L. Curry of Wheeling, a member of the Council of the West Virginia State Medical Association, has been elected a Fellow of the American College of Radiology.

Doctor Curry was among 66 radiologists admitted to fellowship at the annual convocation of the college in Los Angeles on February 3.

Doctor Curry received his M.D. degree in 1946 from Hahnemann Medical College in Philadelphia. He is affiliated with Ohio Valley General Hospital in Wheeling and Martins Ferry Hospital in Martins Ferry, Ohio.

15th Tri-State Conference On Pulmonary Diseases

The 15th Tri-State Conference on Pulmonary Diseases, sponsored by the Thoracic Societies of West Virginia, Virginia and North Carolina, will be held in Roanoke, Virginia, March 19-21.



Charles E. Andrews, M. D.

William L. Cooke, M. D.

Dr. Charles E. Andrews of Morgantown, Professor of Medicine at the West Virginia University School of Medicine, will present 10 consecutive cases who had diagnostic thoracotomy for various suspected conditions. He will speak on March 20.

Dr. William L. Cooke of Charleston will moderate a discussion of problem cases on March 21.

Other speakers will include: Drs. James P. Mann of Washington; W. S. Schwartz of Oteen, North Carolina; James W. Brooks of Richmond, Virginia; E. S. Ray of Richmond; John L. Guerrant of Charlottesville, Virginia; and W. H. Gentry of McCain, North Carolina.

Further information may be obtained by contacting the West Virginia Tuberculosis and Health Association, P. O. Box 341, Charleston, West Virginia 25322. The Association should be contacted by March 10.

PG Course in Pediatrics In Philadelphia

A five-day refresher course in pediatrics will be conducted in Philadelphia, May 1-5, for pediatricians and general practitioners.

The course will be sponsored by The Children's Hospital of Philadelphia and the Department of Pediatrics of the University of Pennsylvania School of Medicine.

The registration fee is $175, and the program has been accredited for 27 hours by the American Academy of General Practice.

The curriculum will consist of lectures and clinics given by the faculty staff in selected aspects of contemporary pediatrics in which important advances are being made.

Registration and inquiries should be sent to Children's Hospital of Philadelphia, Postgraduate Education Committee, 1740 Bainbridge Street, Philadelphia, Pennsylvania 19146.

Winter Meeting of the Council In Charleston on Jan. 29

The Winter meeting of the Council was held at the Daniel Boone Hotel in Charleston on Sunday, January 29, 1967, with the Chairman, Dr. Seigle W. Parks of Charleston, presiding.

The principal items on the agenda were a report and recommendations of the Legislative Committee and consideration of a proposed demonstration regional health service project under Section 202 of the Appalachian Regional Development Act of 1965.

Report of Legislative Committee

Dr. Frank J. Holroyd of Princeton, Chairman of the Legislative Committee, presented a report of a meeting which was held on Saturday evening, January 28.

He reported that the Committee had agreed unanimously that the Association should actively support the "Good Samaritan Bill" and a bill pertaining to the statute of limitations in connection with malpractice actions against physicians.

He also stated that every effort should be made to impress upon members of the Legislature the importance of appropriating funds for implementation of the Medical Examiner's System.

As this issue of *The Journal* was placed on the press, the "Good Samaritan Bill" had been passed by both the House of Delegates and the Senate and was awaiting the signature of the Governor. As finally passed, the bill provides immunity to all persons in connection with rendering emergency medical care to injured persons at the scene of accidents.

The malpractice bill was introduced early in the session and referred to the Judiciary Committees. The bill was considered by the House Judiciary Committee and later was tabled. There has been no action on the part of the Senate Judiciary Committee.

The Council considered a number of other bills affecting the medical profession and approved the report of the Legislative Committee. Complete reports concerning action by the Legislature on bills of interest to the profession are incorporated in "Legislative Bulletins" which are being mailed to members of the Association during the 60-day session.

Appalachian Regional Commission

There was considerable discussion concerning the efforts of a number of component medical societies and interested citizens in Southern West Virginia to obtain the approval of a demonstration regional health service project in that area.

Dr. James S. Klumpp reported that a meeting had been held in Charleston on Thursday, January 26, for the purpose of discussing the proposal submitted to the Health Advisory Committee of the Appalachian Regional Commission. He said the meeting was attended by Dr. Charles H. Boettner, Executive Director of the Health Advisory Committee of the Appalachian Regional Commission; Mr. Angus E. Peyton, Commissioner of the State Department of Commerce; two West Virginia members of the Health Advisory Committee; and representatives of the State Medical Association.

Following a lengthy report concerning meetings between representatives of the State Medical Association and the Appalachian Regional Commission during the past nine months, the Council adopted the following resolution unanimously:

> The Council of the West Virginia State Medical Association is deeply concerned with any matter which is pertinent to the improvement of general or special health services to the citizens of this State. The Council is also interested in the maintenance of all rights, privileges and responsibilities which rightfully belong to the private sector of medical practice. The Council has received a request for approval of a demonstration Regional Health Service Project, under the aegis of the Appalachian Regional Commission, from the component medical societies and a group of interested citizens in Mercer, Raleigh, McDowell, Mingo, Logan, Summers, Wyoming, Monroe and Fayette counties.
>
> THEREFORE, BE IT RESOLVED, The Council approves the development and operation of said health service project in the counties named, under the following conditions:
>
> (1) The operation of county or regional health service centers shall not infringe upon the private practice of medicine;
>
> (2) Services shall be rendered at a cost commensurate with the patient's social and economic status;
>
> (3) There shall be adequate medical representation on all national, state or local bodies having supervision or jurisdiction in the development and operation of these health service projects; and,
>
> (4) These projects shall in no way be developed or operated in a manner which could lead to a government-controlled system of medical practice.

The Council also adopted unanimously a motion specifying that the Health Advisory Committee include the above mentioned conditions in any statement prepared for release to the press or any other groups.

Election of Honorary Member

The following physician was elected to honorary life-time membership in the West Virginia State Medical Association:

Society	*Physician*	*Address*
Cabell	Ivan R. Harwood	Huntington

Continuing Medical Education

Dr. Pat A. Tuckwiller of Charleston, Chairman of the Committee on Medical Education and Hospitals, presented a report on a meeting held in Charleston on January 8. He said the Committee at that time adopted a timetable for implementing a postgraduate education program and said it was hoped that a program may be planned in one or more of the eight geographical areas of the State by early fall.

He said the coordinators in the eight areas were currently in the process of surveying the hospitals in their regions to determine which hospitals might serve as suitable locations for medical education programs. He also said a questionnaire would be mailed

in February to all members in an effort to determine what is needed in the way of postgraduate education.

Doctor Tuckwiller reported that the Committee voted to propose to the Council that it recommend to the Board of Governors of West Virginia University that a position of Coordinator or Director of Postgraduate Medical Education be established in the School of Medicine. It was further recommended that the Coordinator or Director be given faculty academic rank commensurate with his duties and capabilities.

The Council unanimously approved the report and recommendations presented by Doctor Tuckwiller on behalf of the Committee.

Report of Medical Economics Committee

Dr. George R. Callender, Jr., and Dr. Harry S. Weeks, Jr., Co-Chairmen of the Committee on Medical Economics, presented reports on the various third-party medical programs. They reviewed recent discussions held with several department heads.

Doctor Callender reported that a letter was being prepared for mailing to individual members and presidents of the component medical societies concerning usual and customary charges and direct billing in relationship with all third-party programs.

Doctor Weeks reported he had been informed that Commissioner L. L. Vincent of the Department of Welfare had recently interviewed several physicians interested in accepting the position of Medical Director for the Department. He said the Commissioner indicated he hoped to have the position filled by February 1.

The following members of the Council were present: Dr. Seigle W. Parks of Charleston, Chairman; Dr. Richard E. Flood of Weirton, President; Dr. Richard V. Lynch, Jr., of Clarksburg, President Elect; Dr. Richard W. Corbitt of Parkersburg, Vice President; Dr. A. C. Esposito of Huntington, Councilor-at-Large; Drs. Maynard P. Pride, Morgantown; S. Elizabeth McFetridge, Shepherdstown; R. L. Chamberlain, Buckhannon; Andrew J. Weaver, Clarksburg; I. Ewen Taylor, Huntington; William E. Gilmore, Parkersburg; Buford W. McNeer, Hinton; A. J. Villani, Welch; W. P. Bittinger, Oak Hill; and George R. Callender, Jr., Charleston; and Mr. William H. Lively, Secretary ex-officio, and Mr. Edward D. Hagan, Executive Assistant.

The meeting also was attended by Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. C. A. Hoffman of Huntington, AMA Delegate; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. George F. Evans of Clarksburg, Editor of *The Journal*; Dr. James S. Klumpp of Huntington, Parliamentarian; Dr. N. H. Dyer of Charleston, Director of the State Department of Health; Dr. Harry S. Weeks, Jr., of Wheeling, Co-Chairman of the Medical Economics Committee; Dr. Pat A. Tuckwiller of Charleston, Chairman of the Committee on Medical Education and Hospitals; Dr. Daniel Hale of Princeton; Mr. David B. Weihaupt of Chicago, AMA Field Representative; and Mr. James Imboden of Columbus, AMPAC Representative.

15th ACOG Clinical Meeting In Washington

Approximately 3,000 physicians are expected to attend the 15th Annual Clinical Meeting of the American College of Obstetricians and Gynecologists at the Hilton Hotel in Washington, April 17-20.

The four-day meeting will cover many subjects in the area of obstetrics and gynecology through formal papers, colloquia, panel discussions, correlated seminars, luncheon and breakfast conferences and reports on current research. Also on the program will be medical motion pictures, about 200 industrial and scientific exhibits and closed circuit telecasts of operations from George Washington University Hospital.

Dr. Gates J. Wayburn of Huntington will preside at one of many breakfast conferences on Wednesday, April 19. Doctor Wayburn's conference will cover "Uterine Inertia."

One of the panel discussions will be a debate of the resolution "that there is a role for the nurse-midwife in the United States." Different physicians will take the affirmative and negative positions.

Other panels will discuss the place of therapeutic abortion in modern obstetric practice as seen by the obstetrician, the geneticist and the psychiatrist; drugs in pregnancy; and family planning.

Among the topics of formal papers will be toxemia of pregnancy, the immediate postpartum and post-abortion use of the intrauterine contraceptive device, two evaluations of hormonal therapy for symptoms of the menopause, and septic shock in obstetrics an gynecology.

Programs and other information may be obtained by writing to the American College of Obstetricians and Gynecologists, 79 West Monroe Street, Chicago, Illinois 60603.

W. Va. Chapter, ACS, Lists Spring Meeting

The West Virginia Chapter of the American College of Surgeons will hold its annual Spring Meeting at The Greenbrier in White Sulphur Springs, April 13-15.

Speakers will include Dr. Curtis Artz, Chairman of the Department of Surgery at the University of South Carolina College of Medicine, and Dr. William R. Sandusky of the Department of Surgery, University of Virginia Medical Center.

The program will focus on burns, shock and infection.

Once again, prize winning residents' papers will be presented. The deadline for entries in this competition was February 15.

Dr. Theodore P. Mantz of Charleston is President of the West Virginia Chapter. Other Chapter officers are Dr. Harry F. Cooper of Beckley, Vice President; and Dr. Richard A. Currie of Morgantown, Secretary-Treasurer.

These three members of the West Virginia State Medical Association are serving in the 58th Legislature, which is now in session in Charleston. Left to right are: Dr. Davis W. Ritter of Hinton, Democratic member of the House of Delegates from Summers County; Dr. David W. Mullins of Logan, Democratic State Senator from Logan County; and Dr. John M. Bobbitt of Huntington, Republican Delegate from Cabell County. Doctors Ritter and Bobbitt are serving their first year in the House, while Doctor Mullins is in the third year of his four-year term.

Three Physician-Legislators Get Committee Posts

Three members of the West Virginia State Medical Association who are serving in the 58th Legislature received several committee assignments shortly after the 60-day session was convened.

Dr. David W. Mullins of Logan, Democratic State Senator from Logan County, was given the chairmanship of the Senate Health Committee.

Doctor Mullins, who is in the third year of his four-year term, also serves on the following other Senate committees: Agriculture, Finance, Insurance and Corporations, and Natural Resources.

Dr. Davis W. Ritter of Hinton, Democratic member of the House of Delegates from Summers County, was assigned to the following committees of the House: Agriculture and Natural Resources, Education, and Health and Welfare.

Dr. John M. Bobbitt of Huntington, Republican member of the House from Cabell County, is serving on the Industry and Labor Committee and the Political Subdivisions Committee.

Doctors Ritter and Bobbitt are serving their first year in the Legislature.

Doctor Danowski Addresses Academy

Dr. T. S. Danowski, Chief of the Section of Endocrinology and Metabolism at the University of Pittsburgh School of Medicine, presented a paper to the Fort Steuben Academy of Medicine on February 14.

Doctor Danowski's topic was "Drug Therapy of Diabetes Mellitus."

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1967

March 6-9—New Orleans Grad. Med. Assembly, New Orleans.
March 9-11—AMA-ABA National Medicolegal Symposium, Miami Beach.
March 10-11—AMA Conf. on Rural Health, Charlotte, N. C.
March 12-15—Int. Acad. of Path., Washington.
March 16-18—Sou. Soc. of Anesthesiologists, Charleston, S. C.
March 19-24—Southeastern Surgical Cong., Bal Harbour, Fla.
March 19-24—Am. Col. of Allergists, New Orleans.
March 23-24—W. Va. Ped. Soc., and W. Va. Chap., Am. Acad. of Ped., Morgantown.

April 3-5—Am. Acad. of Ped., San Francisco.
April 7-9—Am. Soc. of Int. Med., San Francisco.
April 10-13—Indus. Med. Assn., New York City.
April 10-14—Am. Col. of Physicians, San Francisco.
April 11-13—Am. Surg. Assn., Colorado Springs.
April 13-15—W. Va. Chap., ACS, White Sulphur Springs.
April 17-20—Am. Col. of Ob. and Gyn., Washington.
April 17-19—Am. Assn. for Thoracic Surgery, New York.
April 19-21—Maryland Medical, Baltimore.
April 23-26—W. Va. Acad. of Oph. and Otol., White Sulphur Springs.
April 24-29—Am. Acad. of Neurology, San Francisco
April 24-26—AMA Nat. Cong. on Environment Health Management, New York City.
April 27-28—Am. Ped. Soc., Atlantic City.
April 30-May 2—W. Va. Chapter, AAGP, Huntington.
April 30-May 5—Int. Col. of Surgeons, Bal Harbour, Fla.

May 2-3—Assn. of Am. Phys., Atlantic City.
May 3—Am. Cancer Soc., Dallas.
May 4-6—Am. Gynecological Soc., Phoenix.
May 6—Am. Col. of Psychiatrists, Philadelphia.
May 7-12—Am. Psy. Assn., Detroit.
May 11-14—Am. Surg. Assn., Colorado Springs.
May 16-19—Ohio Medical, Columbus.
May 28-June 1—Am. Dermatological Assn., Colorado Springs.
May 29-31—Am. Oph. Soc., Hot Springs, Va.
May 29-June 1—Am. Urol. Assn., New York.
May 21-24—Am. Thoracic Soc., Pittsburgh.

June 15-16—Am. Rheumatism Assn., New York City.
June 15-17—Am. Col. of Chest Phys., Atlantic City.
June 16-17—Am. Geriatrics Soc., Atlantic City.
June 17—Acad. of TB Phys., Atlantic City.
June 17-18—Am. Diabetes Assn., Atlantic City.
June 18-22—AMA Annual Con., Atlantic City.
June 22—Annual Preston County Meeting, Kingwood.
June 26-29—Am. Orthopaedic Assn., Hot Springs, Va.
July 14-15—Rocky Mtn. Cancer Conf., Denver.

Aug. 24-26—100th Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.

Aug. 27-Sept. 1—Am. Acad. of Phys. Med. & Rehab., Miami Beach.

Sept. 15-23—AAGP, Dallas.
Sept. 29-Oct. 1—W. Va. Heart Assn., Wheeling.

plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.

Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 9) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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WVU Medical Center
—News—

DR. Richard Currie, Associate Professor of Surgery in the School of Medicine, returned to Morgantown recently after a 60-day tour of duty abroad in the "Volunteer Physicians for Vietnam" program which is being administered by the American Medical Association.

Doctor Currie was assigned to a civilian surgical hospital in Da Nang. He said there are usually two patients to a bed and that the hospital in Da Nang has 400 beds and between 600 and 700 patients.

Although most of the hospitals in Vietnam are over 50 years old, Doctor Currie found the equipment in the hospital in which he worked to be very good. He attributed this to help from the United States.

He said there is a severe shortage of nurses and members of the patient's family usually take care of him during his hospital stay. They camp near the hospital.

During his two-month stay, Doctor Currie also had the opportunity to teach some students from the medical school at Hue. The students were serving internships at the Da Nang hospital after six years of study at the medical school.

Doctor Currie said he would like to return to the same hospital for another tour of duty sometime in the future.

• **Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.**

Visiting Lecturers

A prominent Scottish physician visited the Medical Center, February 2-4, and presented two lectures.

He is William F. Walker, Ch. M., F.R.C.S., F.R.C.S.E., consultant surgeon for the professional surgical unit of the Royal Infirmary in Dundee, Scotland.

His topics were "The Adrenal in Shock" and "The Metabolic Response to Surgery."

The School of Medicine's Department of Surgery sponsored Doctor Walker's visit.

Dr. Kivie Moldave, Chairman of the Department of Biochemistry at the University of Pittsburgh Medical Center lectured at the Medical Center on February 17.

His topic was "The Role of Ribosomes in Biochemical Transcription and Translation Processes."

The lecture was one of a monthly seminar series sponsored by the Department of Biochemistry.

A native of Russia, Doctor Moldave was graduated from the University of California and received his master's and doctorate degrees from the University of Southern California.

These West Virginia physicians were among those attending the regional meeting of the American College of Physicians at the Medical Center, January 20-21. First row, left to right: Drs. German Lizarralde of Morgantown; Robert Drinkard, Jr., of Wheeling; and G. Ralph Maxwell, Charles E. Andrews and Alphonse Edmundowicz, all of Morgantown. Second row: Drs. David Z. Morgan of Morgantown; John Lindsay, Jr., of Fairmont; Harold Warren of Beckley; Ernest Guy of Philippi; and Richard V. Lynch, Jr., of Clarksburg.

SAINT ALBANS
PSYCHIATRIC HOSPITAL

Radford, Virginia

James P. King, M. D., Director

William D. Keck, M. D.
Clinical Director
James K. Morrow, M. D.
Morgan E. Scott, M. D.

Clinical Psychology:
Thomas C. Camp, Ph. D.
Card McGraw, Ph. D.
David F. Strahley, Ph. D.

Edward E. Cale, M. D.
Malcolm G. MacAulay, M. D.
Don L. Weston, M. D.
J. William Giesen, M. D.

Don Phillips, Administrator
R. Lindsay Shuff, M. H. A.
Asst. Administrator
Social Service:
Harold M. Cook, M.S.W.

AFFILIATED CLINICS

Bluefield Mental Health Center
525 Bland St., Bluefield, W. Va.
David M. Wayne, M. D.

Beckley Mental Health Center
109 E. Main Street, Beckley, W. Va.
W. E. Wilkinson, M. D.

Charleston Mental Health Center
1206 Quarrier St., Charleston, W. Va.
E. E. Gimenez, M. D.

Mental Health Clinic
Professional Building, Wise, Va.
Pierce D. Nelson, M. D.

The Month in Washington

• From the Washington Office of the American Medical Association.

THE Johnson Administration's health legislation program this year includes proposals to expand Medicare and limit Medicaid, and more money is being requested for most federal activities in the health field.

President Johnson also has asked Congress for anti-air pollution legislation and stricter anti-water pollution measures.

The President termed Medicare "an unqualified success," but added "there are improvements which can be made and shortcomings which need prompt attention." He proposed that the 1.5 million disabled persons receiving their Social Security and railroad retirement benefits also be included under Medicare. He said "certain types of podiatry" should be included in Medicare benefits. He further directed the Secretary of Health, Education and Welfare "to undertake immediately a comprehensive study of the problems of including drugs under Medicare."

Johnson noted that only 415,000, less than half of the 850,000 total, of nursing home beds in the nation met federal standards and that only 3,000 of the total of 20,000 nursing homes had qualified under Medicare.

To move toward correcting this situation, he wants more money for more health facilities and better health care institutions for the aged.

The President called for extension of existing legislation to improve state and local health planning for the elderly and to launch special pilot projects to bring comprehensive medical and rehabilitation services to the aged.

As for limiting Medicaid (Title XIX of Social Security), Johnson said that a state should not be permitted to have its income ceilings for medical assistance more than 50 per cent higher than the level set for welfare assistance. The Medicaid program, which now gives states carte blanche as to income standards, became the subject of widespread controversy after New York set an eligibility standards of $6,000 net income for a family of four.

The Administration fiscal 1968 budget calls for general fund expenditures of $11.7 billion for carrying out existing and proposed new programs of the Department of Health, Education and Welfare (HEW). This is an increase of $1 billion over current year spending. In addition to the general fund outlays on behalf of HEW, the budget forecasts benefit payment and administrative expenditures in 1968 from Social Security trust funds in the amount of $31 billion, an increase of $5.5 billion over 1967.

Health program highlights of the HEW budget include:

—A five per cent increase to $1.45 billion, for medical research.

	(Dollars in Millions)	
	1967	1968
—Food and Drug Administration	$64	$68

The $4 million increase will be used to: (1) expedite the review and surveillance of new drugs for safety and efficacy, (2) expand extramural research into the side effects of oral contraceptives, (3) expand the program established under last year's Drug Abuse Control Amendments, and (4) to carry out the new Fair Packaging and Labelling Act. The 1968 budget will also emphasize regulation of barbiturates, amphetamines, and other drugs affecting the central nervous system, and a step-up in FDA's food standards program.

—Regional Medical Programs—$16 million.

—The total Children's Bureau budget request for fiscal year 1968 is almost $246 million, an increase of about five per cent or about $11 million over 1967. The largest share of the approximately $11 million increase is $5 million additional for special project grants for health of school and pre-school children.

Doctor Draft

The Army and Navy will draft 2,118 medical doctors and 111 osteopaths starting in July.

The Defense Department said Selective Service was requested to provide the doctors because an insufficient number had volunteered to be able to replace men leaving service after two years' active duty. The Air Force is meeting its needs and will not participate in the summer draft call.

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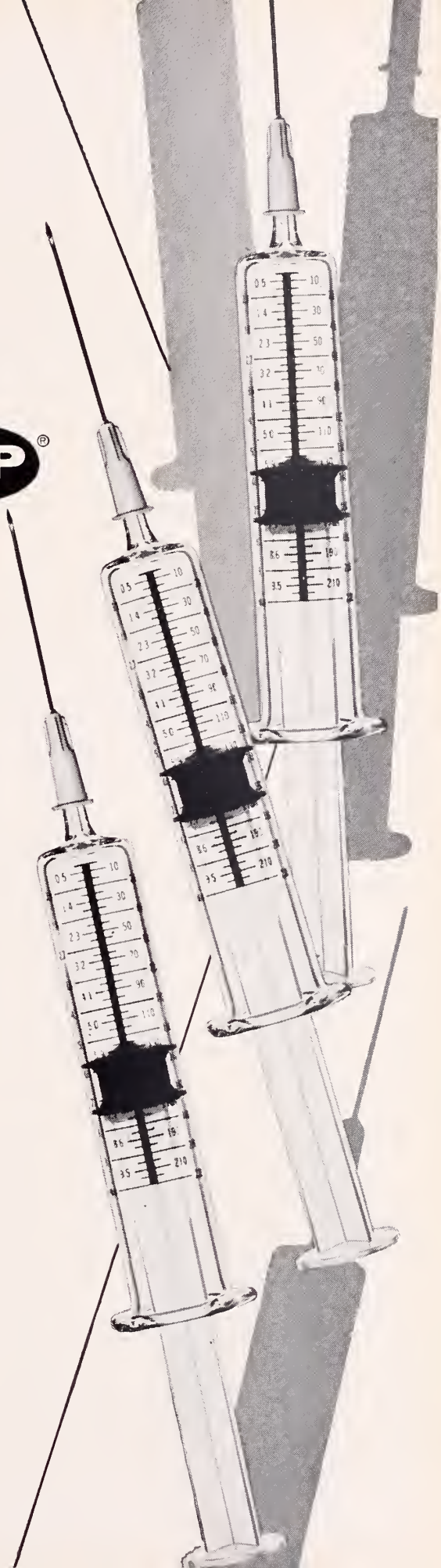

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Vol. 63 No. 4

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston, W. Va. 25324

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50c per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

Member 1967

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The West Virginia Medical Journal

Vol. 63, No. 4 April, 1967

Surgical Treatment of Hiatus Hernia, WVU Medical Center (1960-65)*

Richard A. Currie, M. D., and Jorge Cueto, M. D.

In the majority of cases, esophageal hiatus hernia is an acquired but asymptomatic lesion which is frequently seen in the older age groups. Its clinical importance lies in a small but significant group of patients in which the hernia is responsible for symptoms such as pain, heartburn, flatulence and regurgitation or, less commonly, dysphagia, chronic anemia or acute hemorrhage. Because of frequent association with such disorders as peptic ulcer, cholelithiasis and coronary artery disease, recognition of symptomatic hiatus hernia may be difficult, and proper treatment accordingly delayed.

From the standpoint of complications, the common sliding type of hernia, when associated with active reflux esophagitis, is most to be feared. Progressive scarring in the lower esophageal segment leading to stricture, hemorrhage or instrumental perforation may be the sequel to incompetence at the esophagogastric junction produced by such a hernia.

In spite of the serious nature of some of the complications of hiatus hernia, there is a certain skepticism among clinicians concerning the long-term effectiveness of surgery in this disease. Reports of failure of standard methods of repair in controlling symptoms, together with the frequency of anatomical or radiological evidence of postoperative recurrence have contributed to this point of view. Certainly there is need for more information about many aspects of hiatus hernia, including in particular those factors giving rise to incompetence at the esophagogastric junction and the basis for successful restoration of competence by surgical means. At the present stage of knowledge, it is important to respect the serious potential of hiatus hernia and, in selected cases, to introduce surgery at an early time, prior to the development of irreversible changes in the esophagus, or to the appearance of other urgent indications for surgery in situations involving advanced age and poor surgical risk.

From our own experience we believe that when the surgical indications are recognized and closely followed, the results of operative treatment will be satisfactory in a high proportion of instances.

The Authors

- **Richard A. Currie, M. D., Associate Professor of Surgery, West Virginia University Medical Center, Morgantown.**
- **Jorge Cueto, M. D., Resident in Surgery, West Virginia University Medical Center, Morgantown.**

Clinical Material and Methods

A review was made of all cases in which a clinical diagnosis of esophageal hiatus hernia had been established during the five-year period from August 1960 to September 1965 at the University Hospital, Morgantown, West Virginia. A total of 145 cases in which there were symptoms attributable to esophageal hiatus hernia was found. This group was separated from a much larger group of cases in which asymptomatic hiatus hernia was demonstrated incidentally, at the time of x-ray examination of the upper GI tract. The patients in the group with symptoms consisted of 79 women and 66 men, having a mean age

*Presented at the Spring Meeting of the West Virginia Chapter, American College of Surgeons, at The Greenbrier, White Sulphur Springs, April 15, 1966.

Submitted to the Publication Committee, October 10, 1966.

of 59 years. There were 138 sliding hernias, six parahiatal hernias, and one that could be classed as a composite of sliding and parahiatal types.

Three of the parahiatal hernias and six of the sliding hernias had been previously treated by surgery elsewhere, and gave x-ray as well as clinical evidence of recurrence.

Symptoms related to the hernia are listed in Table 1. Gastro-esophageal reflux was responsible for these symptoms in the majority of cases. Dysphagia was noted in one-fifth of the cases, but was on a basis of stricture or active ulceration in only 11. There were four instances of acute massive bleeding and 16 of chronic blood loss attributed in all to peptic esophagitis or to hemorrhagic gastritis.

The coincidence of gallstones, coronary artery disease and peptic ulcer was frequently seen in this series (Table 2). Reflux esophagitis, as demonstrated by x-ray or by esophagoscopy, was believed to be present in 33 cases or 23 per cent. A clinical verdict of obesity was given in approximately one-third of the cases.

Treatment in Symptomatic Cases

Initial treatment of patients with symptomatic hiatus hernia has involved, in most instances, the use of a bland diet, weight reduction, antacids, sedatives and avoidance of the recumbent posture, particularly after meals. In the majority of cases, the patients have been treated as outpatients and have not required hospitalization either for diagnosis or treatment. Table 4 summarizes the response in a group of 88 symptomatic patients treated by such simple measures. Nearly three-fifths of this number had adequate relief of symptoms with medical treatment over a short followup period (average eight weeks). Prominent in the failures were the cases of patients with large hernias, and those with x-ray or endoscopic evidence of esophagitis.

Surgery was chosen for the treatment of hiatus hernia in 44 cases or 30 per cent of the group. In these cases, the patients had failed to gain relief on medical therapy. Six cases in which the patients had recurrent hernia and intractable symptoms were included in this category. Predominant symptoms were on the basis of reflux esophagitis, but cases in which there was established stricture were not included in the group, and treatment consisted of repeated dilatation or reconstructive procedures.

Thorough preoperative screening of all operative candidates was carried out, and this included evaluation of the patient from the standpoint of operative risk. Coexisting coronary artery disease, obesity, diabetes mellitus and chronic pulmonary disease were considered most important in this regard. Careful study of the status of the gallbladder and biliary tree, as well as the stomach and duodenum, was undertaken prior to a decision being made concerning operative therapy. In the majority of cases, the patient underwent esophagoscopy when symptoms of reflux were present, or when any question of ulceration or stenosis in the lower esophageal segment was raised by the radiologist.

Table 1. Symptoms of Hiatus Hernia in 145 Patients

Chief Complaint	*No.*	*Per Cent*
Epigastric or substernal pain (heartburn)	107	74
Pain related to posture	76	52
Regurgitation of food	64	44
Nausea and vomiting	53	37
Dysphagia	33	23
Bleeding	20	14

Table 2. Associated Disease In 145 Patients With Hiatus Hernia

Esophageal Lesions	*No.*	*Per Cent*
Reflux esophagitis	33	23
Stricture and/or ulcer	11	8
Epiphrenic diverticulum	7	
Peptic Ulcer	16	11
Gastric	4	
Duodenal	12	
Ulcer Diathesis	30	20
Duodenal Diverticulum	18	12
Cholelithiasis	57	39
Arteriosclerotic Heart Disease	56	38
Diverticulosis	45	31

Table 3. Operative Procedures In 44 Patients

Transthoracic Repair	7
Transabdominal Repair	6
T-A Repair, Vagotomy & Pyloroplasty	15
T-A Repair, Gastric Resection	4
T-A Repair, Cholecystectomy	8
T-A Repair, Splenectomy	4

Table 4. Comparison of Results of Medical and Surgical Treatment of 132 Patients

Medical (88 Patients)	*Surgical* (44 Patients)
18 Good (20.5%)	29 Good (65.9%)
34 Satisfactory (38.4%)	8 Satisfactory (18.1%)
36 Poor (41%)	6 Poor (13.6%)
0 Death	1 Death (2.3%)

Table 5. Complications of 44 Hiatus Hernia Repairs

Myocardial infarction*	2
Pulmonary embolism	2
Thrombophlebitis	3
Incisional hernia†	7
Wound dehiscence	1
Pneumothorax	3
Gastric atony	1

* Postop death (1)
† Late death (1)

The transthoracic surgical approach was chosen in seven cases (Table 3) because of previous upper abdominal surgery, extreme obesity or the large size of the hernia. The majority of operations, however, involved the need for thorough abdominal exploration and, frequently, the performance of additional procedures besides hiatus hernia repair (Table 3). The splenectomies were required because of splenic trauma incurred during retraction of abdominal wound edges while the hernia was being exposed or repaired. The choice of vagotomy and pyloroplasty in combination with repair of the hiatus hernia was based on the preoperative finding of esophagoscopic evidence of esophagitis, values of gastric acidity in the ulcer range and evidence of old ulcer by history or at operation. In four cases, in which there was active duodenal ulcer and hiatus hernia, treatment consisted of partial distal gastrectomy and vagotomy.

All operative repairs of sliding hernia, whether carried out through the chest or through the abdomen, involved an infradiaphragmatic approach to the esophageal hiatus. Operative technique included obliteration of the hernia sac, replacement of the E-G junction below the diaphragm, fixation of the phreno-esophageal ligament to the under surface of the diaphragm, and restoration of the hiatus to a more normal size by suture approximation of the limbs of the right crus of the diaphragm. In only a few instances was stomach sutured to diaphragm or to the abdominal parietes. Gastrostomy was not utilized to fix the stomach below the diaphragm. All repairs were elective and were largely carried out by residents under staff supervision.

Results

Evaluation of results covered a postoperative interval ranging from three months to two years, with an average of approximately six months. Thirty-seven of the 44 patients, or 84 per cent of the series, were judged to have had a "good" or "satisfactory" result, meaning that prime symptoms had been relieved or adequately minimized. Six, or 13.6 per cent, had a poor result, with persistence of symptoms following surgery. There was one death, and that was in the case of a patient with known coronary artery disease who sustained a myocardial infarct in the early postoperative period. In addition, one patient died following repair of a large incisional hernia six months after successful transabdominal hiatus herniorrhaphy.

Complications of surgery are summarized in Table 5. It will be seen that a significant number of wound complications was encountered. Of these, the majority involved wound disruption leading to incisional hernia—suggesting at least the common occurrence of factors promoting failure of sound wound healing in this group of patients.

Further analysis of the results of operative treatment of these hernias shows that in six instances in which the patient had poor results, all had reflux esophagitis preoperatively, four had peptic ulcer and three had x-ray evidence of some narrowing in the lower segment of the esophagus. In four of the six cases, the patients showed x-ray evidence of hernia recurrence in the follow-up period. Conversely, in several cases in which results were classed as good, follow-up x-rays discovered evidence of persistence of a small sliding hernia.

Comment

The series of cases of hiatus hernia in which the treatment was surgical is relatively small and the follow-up period admittedly short. We are convinced, however, that it demonstrates that the proportion of poor results following a program of selection and careful application of surgery in cases in which there are intractable symptoms will be low. The majority of treatment failures were observed in patients with advanced degrees of reflux esophagitis, especially those with scarring or intense inflammation in the lower esophageal segment.

The surgical technique found by us to be most applicable to the sliding hernia can be described as a modification of the standard Allison type of repair. Combination of the operative repair of the hernia with other necessary procedures such as cholecystectomy, partial distal gastrectomy, vagotomy and pyloroplasty can be justified on the basis of the requirements of the individual patient. We feel that the combined approach, however, has no sound justification when evidence of significant gastro-esophageal reflux or of symptomatic disease in other organ systems is lacking. Avoidance of midline incisions and giving meticulous attention to wound closure would seem wise in the light of the high incidence of wound complications encountered in our own series of cases. Measures to minimize abdominal distention and pulmonary complications would also appear to be important in the post-operative management of these difficult problems.

Summary

A brief account of the surgical experience with hiatus hernia at West Virginia University Medical Center is given. A series of 44 cases selected from a much larger group of symptomatic and asymptomatic patients with demonstrable hernia was followed postoperatively for an interval averaging six months. Pertinent details of surgical treatment, complications and results are re-

ported. In our hands, surgical repair of hiatus hernia in selected cases has proven to be a satisfactory form of treatment.

References

1. Allison, P. R.: Reflux Esophagitis, Sliding Hernia, and the Anatomy of Repair, Surg. Gynec. and Obst. 92:419, 1951.
2. Borgeskov, Pedersen, O. T., & Frederiksen, T.: Oesophageal Hiatal Hernia: A Radiological Follow-Up, Thorax 19:327, 1964.
3. Sweet, R. H.: Analysis of 130 Cases of Hiatus Hernia Treated Surgically, J.A.M.A. 151:376, 1953.
4. Brooks, J. R.: Hiatus Hernia—The Method of Repair: A Comparison of That Done Below the Diaphragm With That Done Above, New England J. Med. 266:233, 1962.

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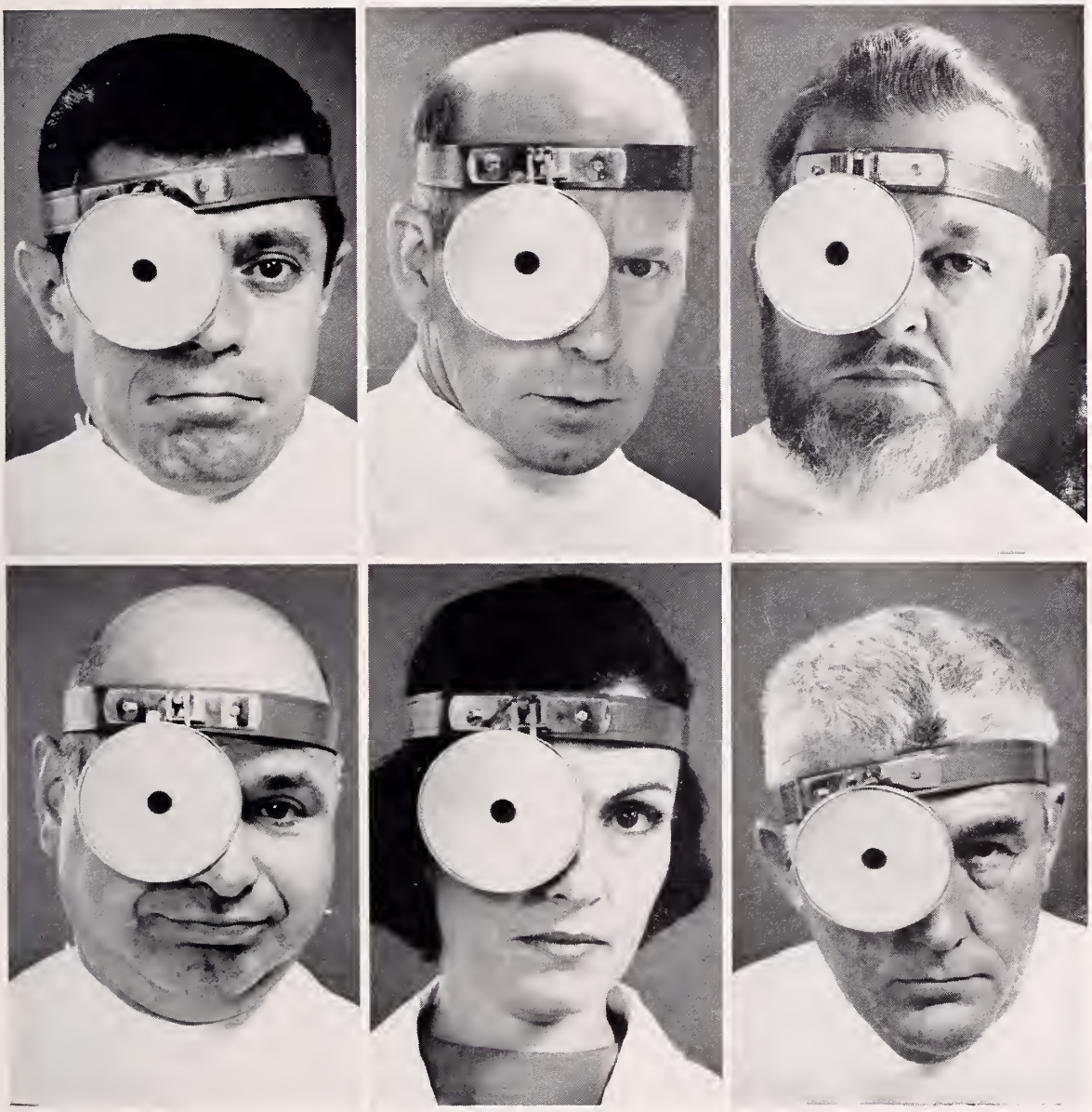

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Please see adjoining page for brief prescribing summary

TA-4913 PC

Allergy and Serous Otitis Media*

Victor L. Szanton, M. D.

THE eustachian tube and its mucous membrane is a continuing tissue connectiing the upper resiratory tract to the middle ear. Physiologically, the response of the mucosa to allergens is similar to that of the nasopharynx. The eustachian tube and the middle ear are, in fact, integral parts of the upper respiratory tract.

The function of the eustachian tube is "to equalize the air pressure in the middle ear—also to provide drainage. The lower two-thirds of the eustachian tube is a collapsed tube which normally opens only during swallowing and in conjunction with certain movements of the jaw, as in yawning."

"The aeration function of the eustachian tube is to supply just sufficient intratympanic pressure to balance the external atmospheric pressure on the drum head, relatively 15 pounds to the square inch."

During an attack of allergic rhinitis the mucosa of the pharyngeal orifice of the eustachian tube may swell, partially or completely blocking this airway. If not quickly reopened, the oxygen content of the middle ear speedily becomes absorbed by blood vessels in its mucosa, with the creation of a partial vacuum. The ear drum and the adjacent ossicle are impaired in the usual function. If the tube remains closed for a considerable length of time, there is a transudate from the blood vessels and the glands of the middle ear mucosa.

Symptoms

"The symptoms of this condition are a feeling of fullness in the head, slight tinnitus and impaired hearing.[1] The hearing loss will fluctuate in severity with seasonal and environmental factors and the allergens that accompany them. It is typically an intermittent hearing loss."

It is in the pre-school child and the child up to nine years of age that the intermittent hearing loss most frequently is found[2] and it is the allergic child with serous otitis and intermittent hearing loss with which we are most concerned. So often this type of hearing loss is overlooked and the individual concerned is misdiagnosed to be immature, to be dull, to have a short attention span. In a study of referral diagnoses of preschool children with hearing loss at New York Hospital,[3] at least 60 per cent were referred as mentally defective, aphasic or emotionally disturbed.

The Author

- **Victor L. Szanton, M. D., Derby, Conn., Assistant Professor of Pediatrics, Albert Einstein School of Medicine, New York City, and Chairman of the Pediatric Section, American College of Allergists.**

To the adult whose vocabulary is well established and who has a normal reservoir of language experience, the partial, scattered, fluctuating obliterations of speech sounds which mark such allergy-linked hearing disturbances may be annoying but they seldom are incapacitating. The adult is able to make up for them by an understanding of the context of the situation and a memory of and familiarity with customary language usage. The young child has no such reservoir to draw upon. Daily he is subject to a bombardment of new experiences and unfamiliar words. The typical hearing loss which is a part of a child's allergic response generally is not of such severity as to draw attention to itself as such. Seldom is such a child taken to an otologist since the hearing loss is not of a magnitude to be a presenting symptom. The degree of hearing loss which in itself may be of little practical significance can, therefore, become a substantial handicap to a child when it blocks the only channel through which so large an amount of learning must make its way.

Effect of Condition Upon Speech

In addition to the education retardation the quality of speech production may be affected. West[4] points out that the effect of hard-of-hearing conditions upon speech depends, among other things, upon the age of the patient at onset of the aural impairment. In their study, "Effects of Limited Hearing on the Development of Speech in Children," Huising and Pollack state, "The development of speech implies the learning by imitation of the basic phonemes and usually occurs between the ages of one and three. Through constant visual and auditory stimulation, listening habits are established for

*Presented before the Ninth Annual Meeting of the West Virginia State Society of Allergy, held during the 99th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25-27, 1966.

Submitted to the Publication Committee, September 30, 1966.

all types of sound. These listening habits do not develop normally in children with limited hearing.[5]" The corollary to this is that the quality of speech development and production is basically a reflection of the way a child hears. The problem then poses itself in whether the child with upper respiratory allergy disease has or has not, as a complication, serous otitis and the intermittent hearing loss that accompanies it.

Diagnosis of Serous Otitis

The diagnosis of serous otitis can be readily confirmed. The condition is most frequent in children up to approximately nine years of age. Reports in the literature state that serous otitis may occur in as many as 66 per cent of children in this age group who have allergic rhinitis.[2] A careful history taken informally and on at least three different occasions often will elicit a contributory family history as well as a history of delayed speech development or of faulty speech. Such a history should arouse one's suspicion. Apparent auditory inattention on the part of a child during seasons of allergic stress should be noted. Other contributory information obtained from a history may include mouth breathing, snoring and lymphoid hyperplasia, particularly with a history of repeated tonsillectomy. These suggest unrecognized upper respiratory allergic disease just as do complaints of "blocked up ears" and repeated ear infection. A history of unsuccessful treatment is helpful. This is particularly true when it refers to repeated aspiration and myringotomy, teflon tubes and antibiotics used without the benefit of simultaneous, specific hyposensitization therapy.

Physical Examination

In doing the physical examination, attention is first of all focused on the ear drum. Its appearance, best seen under good artificial light, is variable, but in most cases the normal mirror-like lustre is gone. The drum may have a creamy-white appearance or an amber or gray discoloration. The malleolus, often chalky-white, are amost pathognomonic of a chronic case. The second most important finding is the immobility of the drum. This is recognized by using the speculum pneumoscope. Fluid levels and bubbles seldom are seen since the drum usually is thickened and scarred. Needle aspiration and myringotomy yield specimens of fluid that are helpful in diagnosis. The fluid obtained usually is sterile, clear and of amber tint. Tuning fork tests are of value. The Weber and Rhinne tests are of great help in differentiating nerve deafness from conductive deafness. It is important to stress the fact that the hearing loss in allergic serous otitis is a conductive one. Pure tone audiograms will show the degree of hearing loss. Repeated tests will show fluctuating hearing loss contrasting times of allergic stress with those free of allergic activity. A positive Kuhn test, i.e., improved hearing as noted by comparing audiograms before and after .1 cc. of adrenalin given hypodermically, is strongly suggestive.

The nasal mucosa usually is as classically described, edematous, hypertrophic, pale or bluish-gray, with clear, mucoid secretions, Eosinophilia of 10 per cent or more of the cells of a nasal smear is considered confirmatory of nasal allergy.

Treatment

Once diagnosis is established, treatment must be started promptly. Hearing must be restored and the allergic condition brought under control. It is necessary to administer both allergic and nonallergic treatment simultaneously. This can be accomplished with the cooperation of an allergy-minded otologist.

Allergy studies must be carried out to pinpoint specific allergens. Since the greatest allergic stress comes from pollens, molds and inhalants, and since these are readily identified by skin tests, the latter constitute a basic requirement. Complete testing of all suspected inhalant allergens is required, first, by scratch skin tests, followed by intradermal skin tests and, if need be, by ophthalmic and intranasal testing to pinpoint suspected, specific etiology. Environmental control of inhalants such as house dust, feathers, and elimination of pet and animal danders is of value. Food testing is best done by elimination diet, provocative testing by ingestion and by careful, simultaneous study of food diary in conjunction with complaints and symptoms. The most common food offenders are cow's milk, eggs, chocolate, peanuts and wheat, although these usually are of a minor nature compared to pollens and inhalants.

Upon completion of skin testing a hyposensitization routine should be started, using as many extracts as are indicated by history and corroborated by positive skin test findings as well as the judgment of the attending allergist. Antibiotics are required at times of bacterial infection as are antihistamines and oral decongestants to help comfort the patient as well as to keep the allergic condition controlled.

From the viewpoint of the otolaryngologist, adenoidectomy and tonsillectomy must be considered as well as needle aspiration of the middle ear. If fluid reaccumulates, the use of teflon tubes should be considered. Their use not only helps restore hearing but prevents development

of a chronic adhesive process that may be irreversible. Treatment in other words, must be multiphasic, must be administered promptly and simultaneously to restore hearing, prevent chronic serous otitis and bring the allergic disease under control.

It is not infrequent, then, that the young child with allergic rhinitis may have a history of delayed or faulty speech development. He may be considered dull or inattentive and may be doing poorly in school. Such a child may prove, upon investigation, to have a previously unrecognized intermittent hearing loss, a complication of allergic rhinitis. Treatment calls for combined team work of pediatrician, otolaryngologist and allergist. Such an approach, well planned, carefully managed and promptly instituted, yields, as a rule, excellent results in aural and, subsequently, scholastic rehabilitation as well as in control of allergic disease.

Allergy and its association with serous otitis media is a relatively recently understood facet of allergic disease, a frequently unrecognized complication which presents an additional challenge in therapy. In most instances, its recognition will afford gratifying results to those involved in the problems of allergic disease and its complications.

References

1. Jackson, J. J. & Jackson, C. L.: Diseases of the Nose, Throat and Ear, Philadelphia, W. B. Saunders Company, 1959, pp. 359.
2. Szanton, V. L. & Szanton, W. C.: Hearing Disturbances in Allergic Children, Ann. Allergy 19:1177-1187.
3. (31) Unpublished report.
4. West, R. B.: Practice of Pediatrics 14:4.
5. Huising, H. C. & Pollock, D.: Effect of Hearing on Development of Speech in Children Under Three Years of Age, Pediat. 8:53 (July) 1951.

Deskside Manners

A good bedside manner was a valuable attribute of the old-time physician. Patients recognized and expected their own M. D. to have such a manner. They still do. However, with advances in transportation and in medical techniques, more and more patients see their physician in his office. The person-to-person relationship still obtains, but under different circumstances. The office patient is less ill and more observant. The physician sitting at his desk is more hurried and harried. He is subject to more interruptions, especially by telephone calls, or by his assistants darting in and out with messages and reports.

The patient can even feel neglected. Even worse, the physician can fail to take a thorough history. Confidences and worries are not readily disclosed during interviews which are repeatedly interrupted. The physical survey can be an ordeal, especially to a female who has her pelvic examination broken into three phases by telephone conversations. Such situations can be avoided. Office personnel can be instructed to take down telephone numbers. These can be answered later. Messages can also be placed on the M. D.'s desk during patient examinations. Of equally great value is the insistence upon allowing ample time for each appointment, with spare time for emergencies.

Just as a long distance runner learns to pace himself, each physician has to establish his own patient velocity. He does not need to care for all his patients at once. A good deskside manner should be an attribute of the modern physician.—*Massachusetts Physician.*

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Not indicated in children under 6 years; absolute dosage for 6 to 12 year-olds not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age.

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Mental Retardation and the General Practitioner*

Richard E. Flood, M. D.

It is indeed a pleasure for me to be listed as a participant in such a distinguished array of names and titles of presentations. I wish I could gather up the words to clear the air for this conference on "Mental Retardation—Prevention and Potential." It is only conferences of this nature and continuing research and application of findings that will conquer retardation as so many other diseases have been conquered.

A few years back, in the late 1930s and early 1940s, conferences such as this were unheard of because no knowledge existed as to what to do and when to do it. It has been only in the 1960s that any inroad has been made concerning mental retardation.

Mental retardation refers to a significantly subaverage intellectual functioning which manifests itself during the developmental period, being characterized by inadequacy in adaptive behavior and continuing after this developmental period into adulthood.

Early Diagnosis

With the skills at our command today, one need not wait until school time to make a diagnosis. Such a diagnosis of mental retardation is now readily made in infancy and early childhood prior to school time.

There was a time when the general practitioner would see all these children *first,* but today the "primary physician" may be an obstetrician, a pediatrician, a neurologist, or, in fact, any doctor who may originally encounter the patient and his problem. More than 200 causes of retardation have been established, but in most cases the physician will not make a specific etiologic diagnosis. Thus, there is no neat class in which to place these mentally retarded persons.

The physician's approach, except for a few certain biologic causes, will be that of treating the individual's symptoms and treating the parents. He will advise them, and in fact act as a "traffic regulator." The doctor must realize that contrary to all others with whom the child and family come in contact, his will not be a temporary role. On the contrary, his professional relationship with the child and family will continue during the individual's total life span. A child today is an adult tomorrow. All the experiences of the doctor and of his colleagues, together with consultations with the family and the total use of community facilities, will bring this child to the best possible adult life with the limited provisions available to the mentally retarded individual.

Problems in all stages of life will necessarily present themselves. The initial shock to the parents is in finding out that the "good baby who sleeps most of the time" is "good" because of his mental retardation. Care and training from that day on must be guided by the doctor and each case must be individualized because, although mental retardees may fall into a group, their actions and responses will vary with each individual. Steps of training in infancy and preschool time will be slow in carrying out, will be tedious and will be laborious.

School Age Symptoms

At school time such traits as insolence may manifest themselves because of this retardation. This behavior continues into adolescence with the problems of puberty which the physician must be cognizant of and able to help. It is at adolescent time when community help tends to dwindle and offers little for these people.

Delinquency may step in as an expression of hostility and frustration toward a society making increased demands on limited abilities. This the doctor must show to the parents and to the law, and other means of education should be brought into play.

Preparation for Adulthood

The ultimate goal of these steps must be an adulthood in which the mentally retarded can live. If an education to the middle grade school—fourth, fifth or sixth grade—can be obtained, the retarded individual could handle an unskilled job, marry, have a family and become an inde-

The Author

- **Richard E. Flood, M. D., Weirton, President, West Virginia State Medical Association.**

*Presented before a seminar on "Mental Retardation—Prevention and Potential," in Charleston, November 15, 1966. Submitted to the Publication Committee, November 15, 1966.

pendent member of the community. Trainable individuals can be rehabilitated formally by Vocational Rehabilitation or the United States Employment Service. It is true, however, that the employment of the retarded is not real security because they are the last hired and the first fired.

The doctor's support, when a job is found for these people, goes far in making it a more permanent job. This is part of the continuous contact the doctor and mental retardees must maintain in order to keep the retardees working or to encourage them to find other jobs.

Sheltered Workshops

Another group, more retarded, may be given tasks to do in a sheltered workshop. The good here is immeasurable and many, many more such workshops certainly need to be created for this group which cannot find work otherwise.

No mention has been made of any coexisting physical handicaps complicating mental retardation. These certainly make the guiding task more complicated but with diligent planning, the same results can be obtained.

Summary

To recapitulate, then, the doctor must be the guiding hand in preparing those retarded for a useful community life. The dilemma begins when the parents must be told. It is imperative that both parents be told of this condition at the same time, because it saves repetition and relieves one parent of the burden of explaining to the other that the child is mentally retarded. A firm but gentle hand must guide the parents along with the child through the period of preschool, school, adulthood and even into marriage. There is no reason why most of the retarded cannot have a family of normal children.

In order to provide direction, the doctor must keep abreast of developments by seminars such as this, and by diligent reading of articles and the newer textbooks. Medical students and paramedical groups, as well as educators, must be taught this, and they can only become aware of such activities by spending time in clinics for the mentally retarded and watching them grow and master the extreme of which they are capable. Only then will research and education go hand in hand into combat against mental retardation.

Patient As a Person

The patient is a person. A person is not a combination of body and soul but rather body and soul as one. Health is profoundly related to one's way of thinking, to one's sense of values; physical well-being and the chemistry of the body are not independent of the condition of the inner man. The survival of the patient does not depend on the pharmacist alone. The doctor must find out the pressure of the blood and the composition of the urine, but the process of recovery also depends on the pressure of the soul and the composition of the mind.

Physical vigor alone does not constitute total health. Nor is longevity the only purpose of living. Quality of living is as important as quantity of living. The achievement of personhood, being human, will do more for health than all medical inventions put together.—*Rabbi Abraham Joshua Heschel, in AMA Symposium on Medicine and Religion.*

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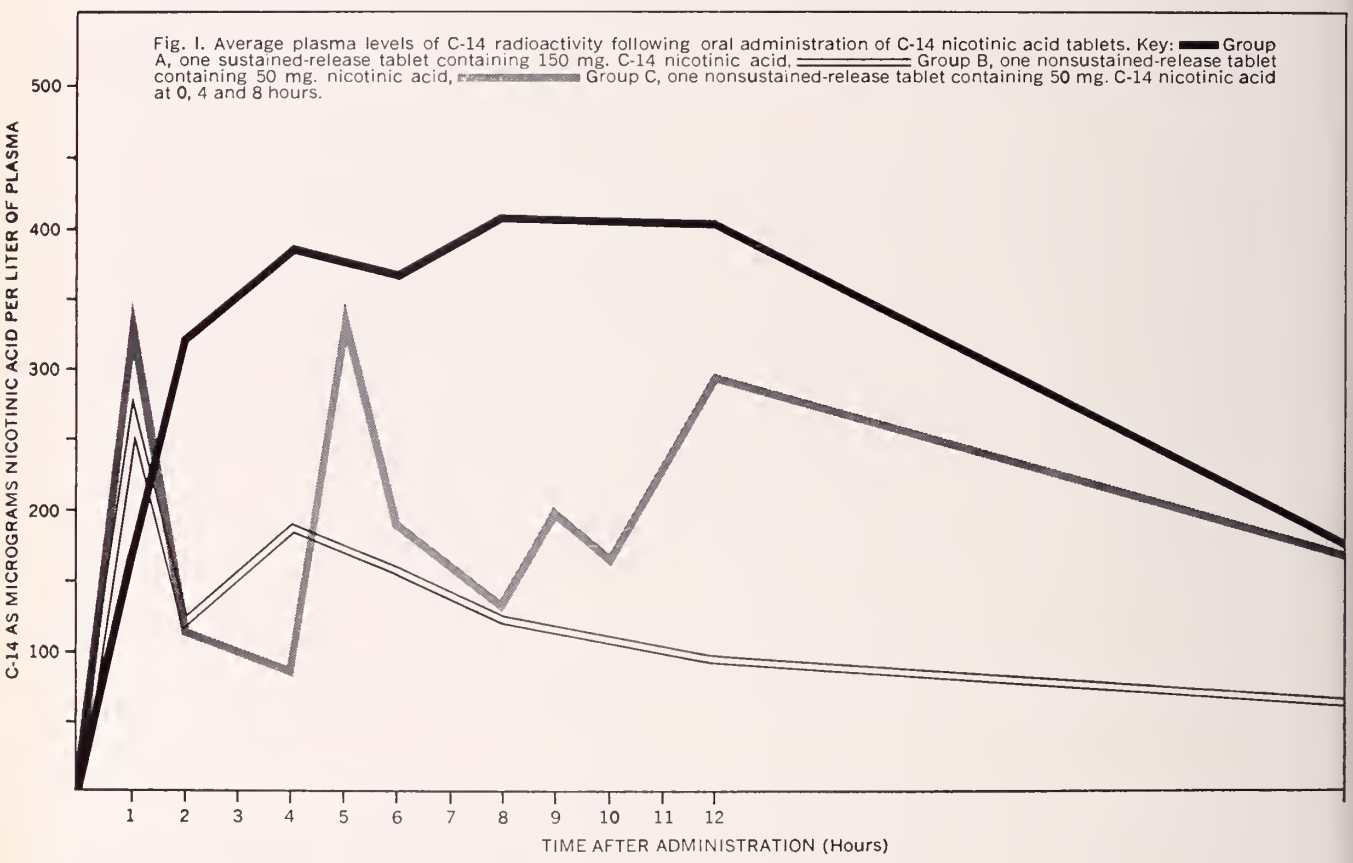

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

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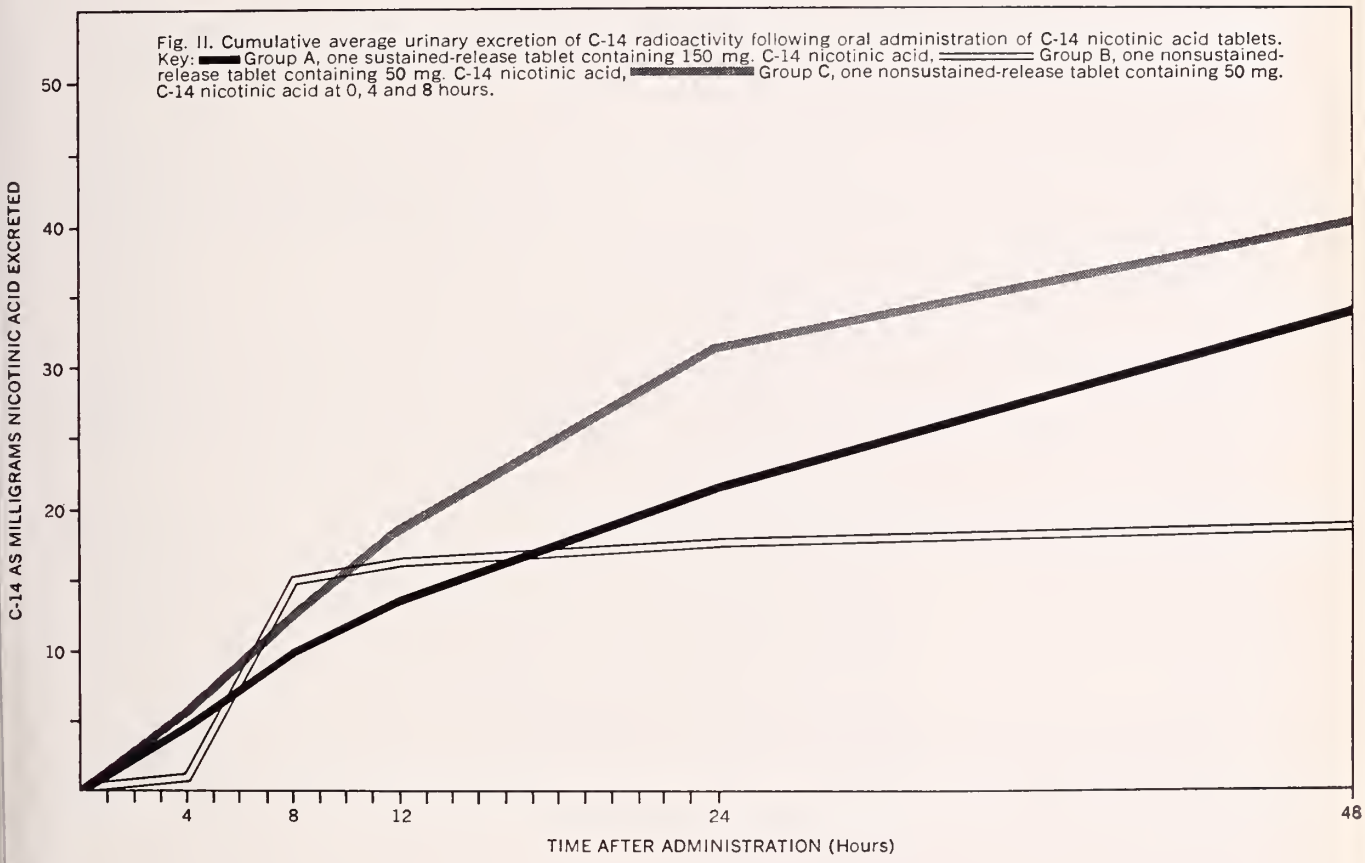

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Special Article

The Podiatrist—An Important Aid To the Medical Profession

H. Darrel Darby, D.S.C.

"*I am convinced that doctors of medicine, myself included, have paid too little attention to the feet in relation to the condition of the patient, and have made too cursory an examination of the feet . . . When care and treatment of such conditions are necessary they (doctors of medicine) should refer the patient to those accredited and skilled in that specialty—the chiropodist-podiatrist.*"—Charles W. Mayo, M. D.

Youngest of the health professions, podiatry is one of the four that may treat patients medically and surgically. As with other healing arts practitioners, podiatrists had their origin in the Guilds of Europe. Fourteenth century health services included the barber surgeon, physician, podiatrist, alchemist and midwife—all of whom provided some form of care. But whereas medicine, and later dentistry, advanced notably, podiatry remained relatively unknown until recent years.

Licensed in every state, plus the District of Columbia and the Commonwealth of Puerto Rico, the podiatrist has at last emerged as a key member of the nation's health team. He is engaged mostly in private practice but also serves in clinics, nursing homes and on hospital staffs—many times in out-patient, diabetic or metabolic departments. In addition to officer status in the Armed Forces, podiatrists serve in Veterans Administration Hospitals, city health departments, and participate in many other government sponsored programs. A number of podiatrists also serve on faculties of medical schools and schools of nursing.

What of his education and training? Today's foot doctor has a minimum of two years of premedical schooling at a recognized university or college, in addition to four years of didactic, laboratory and clinical instruction at one of the nation's five podiatry colleges. Most present-day podiatry students, however, possess three or more years of university education prior to entering a podiatry college, with upwards of 50 per cent having either a bachelor of science or bachelor of arts degree. Over one-third of podiatry graduates undertake an additional year of internship training before entering practice.

Submitted to the Publication Committee, November 29, 1966.

The Author

- **H. Darrel Darby, D. S. C., Huntington, Member: Medical Licensing Board of West Virginia and National Board of Podiatry Examiners, and President, American Federation of Podiatry Boards.**

The colleges are independent, incorporated, non-profit institutions; governed by charters; supervised by boards of trustees; regulated by state departments of education; and listed in the Directory of Institutions of Higher Education of the U. S. Department of Health, Education and Welfare. Podiatry colleges receive financial assistance from government agencies under the Medical Training Act, Health Professions Educational Assistance Act, Health Science Library Assistance Act, etc.

Program of Instruction

The program of instruction includes over 4,200 clock hours. The first two years are devoted to such basic medical sciences as anatomy, biochemistry, physiology, bacteriology and pathology, while the second half covers the clinical subjects —orthopedics, medicine, surgery, pharmacology, podiatry, roentgenology, among others—relating these to the special needs of the podiatry students.

Each college has a foot clinic where clinical and didactic instruction is coordinated and where internships may be served. Some of these clinics provide as many as 50,000 patient-treatments annually. Exposure to clinical study and training first by observation, then by application under strict supervision, provides the student the opportunity to integrate the various aspects of his training.

On successfully fulfilling both the academic and clinical requirements, the graduate is awarded his doctor's degree. A successful state board examination qualifies him for practice.

In addition to the four-year program, the colleges sponsor internship training, postgraduate and refresher courses and other scientific sessions and seminars.

The colleges of podiatry are all accredited by the Council on Education of the American Podiatry Association. The Council is recognized by the Office of Education, Department of Health, Education and Welfare, as the official accrediting agency for colleges of podiatry. Main responsibilities of the Council are to assure that the public will be served by fully qualified practitioners and that the colleges provide better than adequate facilities and faculties for the training of students.

As the science of foot health in all its aspects—preventive and therapeutic—expands and develops, the colleges of podiatry, under the aegis of the Council on Education, are expected to adapt their curricula in keeping with the most modern, effective techniques and methods known both to this specialty and to the life sciences generally.

An interesting aspect of the educational program for podiatry students is that between 30 and 35 per cent of podiatry college faculties are doctors of medicine.

Foot Disorders of Our Senior Citizens

With Americans now living longer, the care of the nation's feet becomes an ever increasing challenge. Rough estimates indicate that over 80 per cent of our senior citizens have one or more foot disorders. If the nation's foot problems are to be solved, podiatry will have to play a leading role in solving them.

Podiatry services are filling an increasingly important role in the over-all medical care of the patient as evidenced by the number of podiatrists being appointed to hospital staffs, health departments and extended care facilities.

As the physician you can do much to insure the comfort of your patient by referring him to the podiatrist, when treatment of the foot is indicated.

Brand vs. Generic Names

IDENTIFICATION of the source of a product has always been an advantage for the user and, with a product of good quality, a matter of pride for the maker. Nothing was ever devised by mankind, to provide the inspiration for the guarantee of excellence, to rival the custom of a superior workman to sign his work or otherwise identify himself with his creation.

Artisans like Stradivarius have made their names so famous as to make unnecessary the mention of their product. Someone in Washington should tell Heifitz how much money he could save with a "generic" violin. It is self-evident that rules for quality apply to drugs as well as to all other products; and in the case of drugs where casual observation, even by an expert, is of little aid in determining quality, the name, honor and reputation of the maker is of supreme importance.

If large sums of money were to be saved by prescribing generic drugs of unidentified origin, the present suggestions for the universal use of generic drugs might have some rational basis. However, a review of several thousand prescriptions written for a welfare service shows that, if all the drugs were dispensed as generic items, only five per cent of the cost would have been saved from the cost of brand name products. The level of manufacturers' prices for all prescription drugs has been falling for the past several years while the cost of living index has been rising. During this same length of time, the price of patented drugs has fallen faster than the price of nonpatented drugs.

Brand name pharmaceuticals are not expensive; their cost covers the one ingredient without price—the guarantee of highest quality enjoyed by the pride of workmanship. In the life-saving business, a cheap drug might be the most expensive thing in the world.—*The Journal of the Indiana State Medical Association.*

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A message from . . .

The President

1867 — 10 APRIL — 1967

ARE you going to Fairmont to commemorate this historic occasion? Are you doing "the best" for organized medicine? Only *you* can supply the answers by standing up to be counted. A nice affair is in the making for this Centennial Observance in Fairmont, being spearheaded by Dr. G. Tom Evans and the Marion County Medical Society.

We had a real delightful meeting in Wheeling on 28 February. Dr. Harry Weeks et al, did the evening up brown, and I'm sure the original signers of the call for the first annual meeting would have been no more pleased and happy than we were when it was read again. Despite the snow, a marvelous turnout was had and the weather could not dampen this historical event! And thanks to Dr. and Mrs. Greeneltch, who had a "follow-up" affair at their lovely home to add beauty and fineness to this great day of 28 February.

I hope the Auxiliary will please note: Charms, pendants, tie tacks and cuff links bearing the Centennial Emblem are being made and will be ready for sale in about four weeks. Sterling silver will sell for approximately $5 each ($10 for cuff links) and gold will be about $15 each. Any profit you may keep for the AMA-ERF. Any takers?

A meeting of the Appalachian State Medical Societies—12 states included and nine states sent one or more delegates—was held on March 10 at the Statler-Hilton Hotel in Washington, D. C. Of course, the West Virginia State Medical Association (Bill and Ed) made all arrangements and all came away from it feeling as if something was accomplished. Each state representative presented a picture of the Appalachian Development Act in his State, an over-all statement was formulated and agreed upon, and the information was passed on to the AMA for its files.

In addition to the state representatives' presentations, Dr. Charles Boettner and Messrs. John Sweeney and John Whisman of the Appalachian Regional Commission and West Virginia Commerce Commissioner Angus Peyton gave good advice in their talks. A feeling of good relationship was definitely established, and I'm sure glad *we* thought of putting on this meeting.

To sum up then: 1. 10 April 67 in Fairmont. 2. Auxiliary note: Pendants, charms, etc., with profit to AMA-ERF. 3. Thanks for such nice meetings—Wheeling and Washington, etc.

RICHARD E. FLOOD, M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIAL

HELMINTHIASIS IN WEST VIRGINIA

Recently there appeared in *The Journal* an article, "Incidence of *Strongyloides Stercoralis*: A Survey of 200 Routine Admissions to the Veterans Administration Hospital in Beckley, West Virginia," by Reiber and McCoy. This timely contribution calls attention to one of the helminthic diseases endogenous to West Virginia. Although the *Strongyloides Stercoralis* infection was found in only nine of 200 consecutive routine admissions to a medium-sized Veterans Administration Hospital, the figures may be interpreted to mean that the condition, though not highly endemic, is probably widely spread in the Southern Applachian Region. It is even likely that there is sufficient epidemiological data to support the evidence the Strongyloides infection may occur in the adult male population anywhere in West Virginia. It is of interest, for example, that at least six cases have been observed in the University Hospital during the last five years.

Reiber and McCoy point out that the most common clinical symptoms are gastrointestinal disturbances, such as diarrhea, constipation, flatulence, abdominal cramps, and even vomiting. It is true, of course, that such gastrointestinal symptoms may be caused by many different conditions. In making a differential diagnosis, however, the blood picture may be extremely helpful. Helminthiasis is often accompanied by eosinophilia. The authors point out that in their series, out of the seven patients who complained of gastrointestinal discomfort, one had 33 per cent eosinophils, and another 19 per cent. Such a pronounced rise in the eosinophilia count makes the diagnosis very likely.

Incidentally, it should be pointed out that other helminthic diseases occur throughout the State, especially, ascariasis and trichuriasis (whip worm); the latter, of course, is more frequently found in children. Hook worm (*Necator americanus*), too, has been reported; indeed, it has been found as far north as Marshall County.

In essence, it would seem that the clinician should bear in mind that helminthiasis does exist in West Virginia. If he does, he may make a diagnosis which otherwise would be missed.

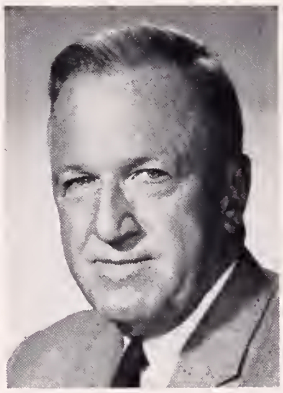
Reiber, C. D., and J. E. McCoy. W. Va. Med. Journ. 63: 42, 1967.

GENERAL NEWS

Drs. Blades and Doan To Speak At Centennial Meeting

Two prominent physicians have accepted invitations to appear as guest speakers at the 100th Annual Meeting of the West Virginia State Medical Association, which will be held at The Greenbrier in White Sulphur Springs, August 24-26.

Brian Blades, M. D.



Charles A. Doan, M. D.

Dr. Ray S. Greco of Weirton, Chairman of the Program Committee, said that Dr. Brian Blades of Washington, D. C., and Dr. Charles A. Doan of Columbus, Ohio, have accepted invitations to present papers during the three-day meeting. There will be three speakers at the general sessions on Thursday and Friday mornings and a special program is being arranged for Saturday morning.

Doctor Blades, who is Lewis Saltz Professor of Surgery and Chairman, Department of Surgery, the George Washington University School of Medicine, also serves as Chief of Surgery at the George Washington University Hospital.

A native of Scottsville, Kansas, Doctor Blades was graduated from the University of Kansas and received his M. D. degree in 1932 from the Washington University School of Medicine in St. Louis. He interned at Henry Ford Hospital in Detroit, and served a residency in surgery at Bellevue Hospital (Cornell Division) in New York City, 1933-36. He also served as a Fellow in Thoracic Surgery at Washington University School of Medicine in 1936. He served as a member of the faculty at his alma mater from 1937-42.

During World War II, he served as Chief of Thoracic Surgery at Walter Reed General Hospital in Washington, D. C., and as a Consultant in Surgery to the Surgeon General, USA. He was awarded the Legion of Merit and was discharged in 1946 with the rank of Colonel.

Doctor Blades is certified by the American Board of Surgery and the American Board of Thoracic Surgery, and he is a member of several surgical societies including the American College of Surgeons.

He is Editor of *The Journal of Thoracic and Cardiovascular Surgery* and he serves on the Editorial Boards of *The American Surgeon, Annals of Surgery* and *Postgraduate Medicine.*

Charles A. Doan, M. D.

Dr. Charles A. Doan, Dean Emeritus of the Ohio State University College of Medicine, has appeared frequently in West Virginia as a speaker at scientific sessions and he has many friends throughout the State.

He was born in Nelsonville, Ohio, and received his M. D. degree in 1923 from Johns Hopkins University School of Medicine. He was associated with the Rockefeller Institute of Research and the Thorndike Memorial Laboratory in Boston, 1924-30.

He served as Professor of Medicine and Director of the Department of Medical and Surgical Research at the Ohio State University College of Medicine, 1930-36.

He was Chairman of the Department of Medicine and Physician-in-Chief at the Starling-Loving University Hospital and St. Francis Hospital, 1936-44. In 1944, he was named Dean and Professor of Medicine of the Ohio State University College of Medicine.

Doctor Doan received the Distinguished Service Award of the American Medical Association in 1960 and is a past president of the American Society of Hematology.

He is certified by the American Board of Internal Medicine and is a member of the American College of Physicians. He served as Chairman of the Board of Governors of the ACP, 1951-54, and he is a member of the Columbus Academy of Medicine, Ohio State Medical Association and the American Medical Association.

Scientific Program Nearly Completed

Doctor Greco announced that arrangements have nearly been completed for the scientific program which will be presented during the three-day meeting. The other members of the Committee are Drs. Richard W. Corbitt of Parkersburg, Robert Greco of Morgantown and Joseph D. Romino of Fairmont.

It was announced previously that Dr. Milford O. Rouse of Dallas, Texas, President Elect of the American Medical Association, has accepted an invitation to appear as the speaker at the first session of the Association's House of Delegates on Wednesday after-

noon, Augut 23. Doctor Rouse will be installed as President of the AMA at the Annual Convention in June.

Further details concerning the Centennial Meeting at The Greenbrier will be announced in future issues of *The Journal.*

Auxiliary Board Meeting In Parkersburg

The Spring Board Meeting of the Woman's Auxiliary to the West Virginia State Medical Association will be held at the Uptowner Inn in Parkersburg on Tuesday and Wednesday, April 25-26.

Mrs. Hu C. Myers of Philippi, President of the Auxiliary, will preside at the sessions. Hostesses will be members of the Woman's Auxiliary to the Parkersburg Academy of Medicine.

State officers, committee chairmen, local auxiliary presidents and presidents elect will participate in the session.

Tuesday's program will include a luncheon and registration and a business session at the Uptowner, with social hour and dinner that evening at the Chancellor Hotel.

On Wednesday, there will be a continental breakfast and a workshop under the direction of Mrs. Rupert Powell of Fairmont, President Elect of the Auxiliary.

The charge for the three meals, including tax and gratuities, will be $7.00.

Physicians who accompany their wives to the meeting are invited to participate in golfing, with Dr. William E. Gilmore as host. Physicians who wish to play should contact Doctor Gilmore at 1911 Dudley Avenue, Parkersburg.

W. Va. Acad. of Oph.-Otol. Meets At The Greenbrier

Approximately 400 physicians and guests are expected to attend the 20th Annual Spring Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology which will be held at The Greenbrier in White Sulphur Springs, April 23-26.

Papers on ophthalmology will be presented by Drs. Alson E. Braley of Iowa City, Iowa; Arthur Keeney of Philadelphia; Donald M. Shafer of New York City; and Joseph A. C. Wadsworth of Durham, North Carolina.

Speakers on otolaryngology will include Drs. Howard P. House of Los Angeles; Wallace Rubin of New Orleans; Sam Sanders of Memphis, Tennessee; and George A. Sisson of Syracuse, New York.

Titles of papers were published in the March issue of *The Journal.*

Programs and other information may be obtained by writing to Dr. J. Elliott Blaydes, Jr., Secretary-Treasurer, 107 Federal Street, Bluefield.

Diabetic Children's Camp Starts July 30

Camp Kno-Koma, the summer camp for diabetic children, will hold its annual session from July 30 to August 12, 1967, near Clendenin in Kanawha County.

The camp is sponsored by the West Virginia and Charleston Diabetic Associations. Any diabetic boy or girl, ages 7 through 15, is eligible, and the cost for the two weeks of camping is $80 per camper.

There will be a full program of activities with continuous medical and dietetic supervision. Drs. John H. Gile of Parkersburg and George P. Heffner of Charleston will serve as medical directors.

Additional information, brochures and application blanks may be obtained by writing to Mrs. George Connolly, Camp Kno-Koma, P. O. Box 8184, South Charleston, West Virginia 25303.

College of Surgeons Meets April 13-15

The Annual Spring Meeting of the West Virginia Chapter of the American College of Surgeons will be held at The Greenbrier in White Sulphur Springs, April 13-15.

Scientific speakers will include Dr. Curtis Artz, Chairman of the Department of Surgery at the University of South Carolina College of Medicine; Dr. William R. Sandusky of the Department of Surgery, University of Virginia Medical Center; and Dr. J. A. Haller, Jr., Associate Professor of Surgery at the Johns Hopkins University.

Prize-winning residents' papers also will be read.

Dr. James H. Spencer of Chicago, Assistant Director of the American College of Surgeons, will be a guest at the meeting.

17 Physicians Licensed by MLB

Seventeen physicians were licensed to practice medicine in the State of West Virginia at a meeting of the Medical Licensing Board which was held in Charleston, January 9-11. The following nine were licensed by direct examination:

Camara, Prudencio B., Hinton
Castro, Renato Camacho, New Cumberland
Coro, Armando Jose, Beckley
Mardones, Arturo O., Spencer
Miao, Chi Hsien, Weston
Morad, Ali Haji, Ripley
Nese, Sevket Turgut, Oak Hill
Possinger, Clive Francis, Jr., Philippi
Zsoldos, Frank Joseph, Jr., Chicago, Illinois

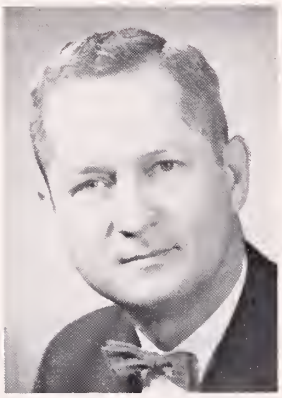
The following eight physicians were licensed by reciprocity:

Brand, Mary Jane, Chester
Johnson, James Carl, Huntington
Kaplan, Kenneth Charles, Morgantown
McClure, Cuvier Dean, Morgantown
Sciple, George Washington, Morgantown
Senft, Robert Arthur, Fairmont
Spelman, Leslie Pratt, Philadelphia, Pa.
Wiles, Isaiah Alonzo, Morgantown

The next meeting of the Medical Licensing Board will be held in Charleston on April 10 for the purpose of licensing physicians by reciprocity.

W. Va. Chap., AAGP, To Meet In Huntington, April 28-30

The complete scientific program has been announced for the 15th Annual Scientific Assembly of the West Virginia Chapter of the American Academy of General Practice, which will be held at The Hotel Frederick in Huntington, April 28-30.



Carroll L. Witten, M. D.

M. Edward Davis, M. D.

The Chapter's business meeting will be held on Friday morning, April 28. This will feature the installation of Dr. Martha J. Coyner of Harrisville as President and the election of other officers for the coming year. A social hour, buffet dinner and entertainment are scheduled for that night.

Dr. Carroll L. Witten of Louisville, Kentucky, President of the American Academy of General Practice, will be the featured speaker at the Annual Banquet on Saturday evening, April 29.

A Past President of the Kentucky Academy of General Practice, Doctor Witten received his M. D. degree in 1951 from the University of Louisville Medical School. He is a former Speaker of the AAGP Congress of Delegates and at present serves as a Delegate to the House of Delegates of the American Medical Association from the Section on General Practice.

Friday Afternoon Program

The scientific program on Friday afternoon will be conducted by the West Virginia Thoracic Society. Speakers and their topics are as follows:

"The Pre-operative Evaluation and Post-operative Care of Patients with Pulmonary Disease"—N. LeRoy Lapp, M. D., WVU Medical Center, Morgantown.

"The Management of Respiratory Insufficiency"—Charles E. Andrews, M. D., Professor of Medicine, WVU Medical Center, Morgantown.

"The Management of the Child with Tuberculosis"—Don Blummer, M. D., Medical College of Virginia, Richmond.

A question-and-answer session will complete the Friday afternoon program.

Saturday Morning Program

Papers on basic science, obstetrics and gynecology and surgery will be presented on Saturday morning. The program is as follows:

"Recent Advances in Pulmonary Physiology"—Charles E. Andrews, M. D., Professor of Medicine, WVU Medical Center, Morgantown.

"Regulation of the Cardiovascular System by the Autonomic Nervous System and Some Pharmacological Implications"—William W. Fleming, Ph.D., Chairman of the Department of Pharmacology, WVU School of Medicine, Morgantown.

"Clinical Observations on the Relationship of the Temporal Lobe to Vestibular Disorders"—James W. Watts, M. D., Professor and Chairman of the Department of Neurology and Neurological Surgery, George Washington University School of Medicine, Washington.

"Treatment of the Patient with Peripheral Arterial Insufficiency"—George H. Yeager, M. D., Professor of Surgery, University of Maryland College of Medicine.

"Pregnancy in Adolescent Unmarried Mothers"—M. Edward Davis, M. D., Emeritus Chairman of the Department of Obstetrics and Gynecology, University of Chicago School of Medicine.

"Management of the Rh Problem"—James G. Sites, M. D., Associate Professor of Obstetrics and Gynecology, George Washington School of Medicine, Washington.

The morning session will be followed by a round table luncheon with a scientific speaker or exhibitor serving as discussion leader at each table.

Saturday Afternoon Program

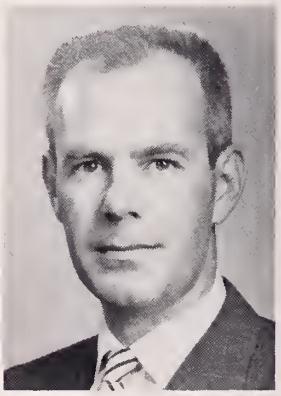
Saturday afternoon will be devoted to discussion of problems in pediatrics and medicine. The program is as follows:

"The Role of the Physician in School Problems"—Earl H. Baxter, M. D., Emeritus Professor and Chairman of the Department of Pediatrics, Ohio State University College of Medicine, Columbus.

"Examination and Treatment of Childhood Strabismus"—John A. Dyer, M. D., Member of a Section on Ophthalmology, The Mayo Clinic.

"The Battered Child"—Joseph M. LoPresti, M. D., Georgetown University and George Washington University Schools of Medicine, Washington.

Earl H. Baxter, M. D.



John A. Dyer, M. D.

"Recent Developments in Diabetes"—H. St. George Tucker, M. D., Associate Professor of Medicine, Medical College of Virginia, Richmond.

"Practical Considerations in the Treatment of Diabetes"—Theodore G. Duncan, M. D., University of Pennsylvania School of Medicine.

"Present Day Status of Contact Lenses"—John A. Dyer, M. D., Member of a Section on Ophthalmology, The Mayo Clinic.

Sunday Morning Program

The final scientific session will be conducted on Sunday morning, April 30, with speakers and topics as follows:

"The Anatomy of Hand Infections" and "Anatomy of Ligamentous Injuries of the Knee Joint"—Robert J. Johnson, M. D., Chairman, Department of Anatomy, University of Pennsylvania Postgraduate School.

"Dermatoses in Children"—Raymond C. V. Robinson, M. D., Associate Professor of Dermatology, University of Maryland College of Medicine.

"Polycythemia—Controversy Regarding Diagnosis and Treatment"—Robert L. Wall, M. D., Professor of Medicine, Ohio State University College of Medicine, Columbus.

"A Psychiatrist Looks at His 50 Years of Contact with General Practitioners"—Ralph N. Zabarenko, M. D., Associate Professor of Psychiatry, University of Pittsburgh School of Medicine.

Dr. Charles M. Caravati, Professor of Medicine at the Medical College of Virginia, Richmond, will present a paper on Sunday morning, but the title of his lecture was not available as this issue of *The Journal* went to press.

Dr. Halvard Wanger of Shepherdstown is Program Chairman for the Scientific Assembly. Dr. Jack Leckie of Huntington is local Program Chairman.

Officers of the West Virginia Chapter are: Dr L. Dale Simmons of Clarksburg, President; Dr. Martha J. Coyner of Harrisville, President Elect; Dr. Del Roy Davis of Kingwood, Vice President; Dr. C. Carl Tully of South Charleston, Secretary; and Dr. James E. Spargo of Wheeling, Treasurer.

Annual Preston County Meeting In Kingwood on June 22

The annual scientific and recreational meeting sponsored by the Preston County Medical Society will be held at the Preston Country Club in Kingwood on June 22.

The Society has issued a cordial invitation to all practicing physicians in West Virginia to attend the one-day session. As usual, there will be golf and trapshooting tournaments in the morning and afternoon followed by a social hour.

The speaker at the banquet that evening will be Dr. Seymore Charles of Newark, N. J., President of the "Physicians' Automotive Safety" organization.

Further information may be obtained by writing to the Secretary of the Society, Dr. C. Y. Moser of Kingwood.

ACP Announces May PG Courses

The American College of Physicians will sponsor three postgraduate education courses during the month of May.

They are as follows:

May 8-12—"Clinical Auscultation of the Heart", Washington, D. C.

May 15-19—"Recent Advances in Clinical Endocrinology", Seattle, Washington.

May 22-26—"Clinical Applications and Recent Advances in Electrophysiology of the Heart", New York City.

Fees for each course are $60 for ACP members and $100 for nonmembers.

Additional information may be obtained from Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Industrial Medical Group Lists Spring Meeting

The Spring Meeting of the Industrial Medical Association of the Pittsburgh-Cleveland Area will be held in Charleston on May 19.

The one-day session will be conducted at the headquarters office of the Chesapeake & Potomac Telephone Company of West Virginia at 1500 MacCorkle Avenue, S. E.

Daniel Hamaty, M. D.

Seigle W. Parks, M. D.

Dr. Edmond R. Plunkett, President of the Association, and Mr. H. A. Latimer of Charleston, Vice President of the telephone company, will give opening remarks at 9:15 A.M. A luncheon will be served in the company cafeteria, and there will be a tour of the building and Medical Department.

The following scientific program has been arranged:

"Tonometry in Industry"—Edwin M. Shepherd, M. D., and James H. Thornbury, M. D.

"Inflammatory Disease of Musculoskeletal System"—George R. Callender, M. D., and Daniel Hamaty, M. D.

"Data Phone Transmission of Electrocardiagrams"—Harold Selinger, M. D.

"Brachial Plexitis"—A. L. Poffenbarger, M. D.

"Sick Absence Control"—Seigle W. Parks, M. D.

Doctor Parks, Chairman of the Council of the West Virginia State Medical Association and President Elect of the Pittsburgh-Cleveland Area Group, is in charge of arrangements. He said that all interested physicians are invited to attend and that advance registration is not necessary.

— February 28, 1867 —

WHEELING MEETINGS

— February 28, 1967 —

On the evening of February 28, 1967, the members of the Ohio County Medical Society, their ladies and invited guests, assembled at the Glessner Auditorium, Oglebay Park, Wheeling, to commemorate the first step leading to the formation of the West Virginia State Medical Association.

Exactly 100 years ago on this date a group of physicians met at the McLure House in Wheeling to discuss the formation of a State Medical Society. At this meeting it was decided "to prepare a suitable call for a Convention to meet in Fairmont on the tenth day of April next."

Dr. Harry S. Weeks, Jr., President of the Ohio County Medical Society, presiding over the 175 members and guests present, stated the theme of the meeting in his opening remarks: "By taking note of this first meeting, we here assembled, have gone on record as expressing our pride in the past century of medical practice in the State and our faith in the future."

Historical highlights relevant to the first meeting were prepared by Dr. James Cummins Hazlett, a capable historian and a descendent of one of the signers of the Circular that went out from Wheeling.

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, in his address to the Society, discussed some of the problems confronting present day physicians in their efforts to provide high quality medical care.

Dr. Richard V. Lynch, Jr., the President Elect, and Dr. Richard W. Corbitt, the Vice President, participated in the ceremonies.

HISTORY

Prepared by James Cummins Hazlett, M. D.

(Presented at the Anniversary Meeting of February 28, 1967)

The Commonwealth of Virginia before the Civil War was a paradox. Divided diagonally by the Allegheny Mountains, the eastern two-thirds, and the western third were as far apart as the Poles. The "Williamsburg" tradition, the great estates and plantations, the landed aristocracy and slave economy had gradually lapped westward across the Piedmont, until stopped by the forbidding bulk of the Appalachian highlands. Access to the mountain regions came from Pennsylvania, where German and Scotch-Irish settlers hacked a precarious existence from the wilderness, still living a pioneer life more than 100 years after the eastern part had become completely civilized. There were few slaves here, and due to the nature of the lands, holdings were relatively small.

Forged in the heat of the Civil War, there is no question but that political expediency aided the formation of the new State of West Virginia. Corners were cut, and there is still some doubt among lawyers as to the legality of the entire business; nevertheless, Abraham Lincoln needed an additional backlog of Republican votes in time for the Presidential elections of 1864. So, the "Old Dominion State" was divided along the physical lines which reflected the differing political and ethnic backgrounds—the North and the South.

Wheeling, in spite of its geographical location in the extreme northern end of the new State, was the hub and center about which revolved most of the economy. Strategically placed on the Ohio River, it had early vied with Pittburgh as the "Gateway to the West"; the National Road, completed not long after the war of 1812, and the Baltimore and Ohio Railroad which terminated here in 1853 pushed Wheeling from a frontier town into a thriving city of 19,000, with almost unlimited industrial potential. The second steamboat built west of the Alleghenies had its keel laid here; the Bridge, at the time it was built, was the longest suspension span in the world. Wheeling was listed as a Port of Entry, and had a Custom's House. It was here that delegates gathered in the late Spring of 1861 to affirm their loyalty to the Union; it was here that our Declaration of Independence from Virginia was signed; and it was here that the seat of Government was located when the new State was formed.

So it is not strange that Wheeling and the Northern Panhandle took the initiative in organizing medicine in West Virginia. Indeed, Ohio County has had a Medical Society which has been active and in continuous existence since 1847, a heritage of 120 years upon which we may look with pride, equal to that which we view our part in the formation of the West Virginia State Medical Association.

There had apparently been an early effort to organize the physicians in Wheeling, as attested by the adoption of a fee schedule at a meeting held at the Lancastrian Academy (later Linsly Institute) October 17, 1835, signed by nine doctors. Little else is known about this society, if it were indeed such.

The Commonwealth of Virginia had made two abortive attempts to form a State Medical Association, once in 1820, which died of inanition about 1824, and again in 1841 which lasted until 1859, being dissolved because of the domination of the organization in Richmond and Petersburg and dissention over the passage of a medical licensing bill. Wheeling enters the picture here when Dr. M. H. Houston was listed as the only representative from the western part of the State to attend the 1841 convention. (In fact, he was the only western representative who belonged to the society).

In 1846, a convention of doctors took place in New York City at the invitation of the New York Medical Society, with the view of establishing a National Society. This resulted in an organization meeting in Philadelphia in May 1847, at which time the American Medical Association was formed.

Doctor Houston had attended this Philadelphia meeting, and on his return, lost no time in attempting to organize the physicians in Ohio County. This was accomplished on July 5, 1847 with the signing of the Constitution and By-Laws by fifteen physicians, among whom were Doctors Houston, Hullihan, Bates, Hildreth, Frizzell and Todd. At this time, the Ohio County Medical Society was one of four in the entire Commonwealth of Virginia, and the only one west of the Alleghenies.

It may be of interest to note that Doctor Houston was one of the nine persons to sign the fee schedule of 1835, and that he was a Southern sympathizer. At the beginning of the Civil War, he went South, and due to his age, was placed in charge of the Confederate Hospital in Lynchburg, Va.

Shortly after the dust of the Civil War had settled, the desirability of instituting a State Medical Association was felt. This prompted the meeting which is described below. Four of the original members of the Ohio County Medical Society (Namely, Doctors Bates, Hildreth, Frizzell and Todd) signed the leter giving the call, as well as three other doctors from Wheeling, and nine physicians representing Triadelphia, Grafton, Fairmont, Clarksburg, Morgantown and Upshur County.

The following is reproduced from the Wheeling Intelligencer, March 1, 1867: "Friday morning: Medical. We understand that an informal meeting of physicians took place in the Parlor of the McLure House Wednesday evening, looking toward the establishment of a State Medical Society. Dr. Bates was called to the Chair, and Dr. Reeves of Fairmont was appointed Secretary. A harmonious interchange of opinion was had and on the motion of Dr. Hildreth, Drs. Reeves and Hupp were appointed a Committee to prepare a suitable call for a Convention to meet in Fairmont on the 10th day of April next. This call will appear in circular form and will be sent to physicians in all Counties of the State. All will agree that this is a work in the right direction."

Dr. Bates was later elected the first President of the State Society.

Centennial Observance Planned In Fairmont on April 10

Dr. William H. Stewart, Surgeon General of the United States Public Health Service, will be principal speaker at a dinner in Fairmont on April 10 commemorating the founding of the West Virginia State Medical Association 100 years ago.

William H. Stewart, M. D.

The dinner at the Fairmont Hotel will be sponsored by the Marion County Medical Society. Dr. Richard E. Flood of Weirton, President of the State Medical Association, and a number of other distinguished guests are expected to attend the meeting.

It was on April 10, 1867, that the first meeting of what is now the West Virginia State Medical Association was held in Fairmont.

At that first meeting in Fairmont 100 years ago, 22 physicians gathered to form the medical society.

This will be the second major event this year commemorating the 100th Anniversary of the Association. Last February 28, a celebration was held in Wheeling marking the 100th Anniversary of the original call for the first meeting. (See story in Historical Section of this issue, page 130).

Doctor Stewart, the principal speaker at the April 10 meeting, has been Surgeon General of the Public Health Service, under appointment by President Johnson, since September 24, 1965. He presides over an agency which employs more than 38,000 persons and spends about $2 billion a year.

A native of Minnesota, Doctor Stewart received his M. D. degree in 1945 from the Louisiana State University School of Medicine. He served a residency in pediatrics in New Orleans and was engaged in private practice in Alexandria, Louisiana, until he entered the Public Health Service in 1951.

His first two years as a Public Health Service Officer were spent in Thomasville, Georgia, where he headed the epidemiological unit of the Communicable Disease Center. He has served in various capacities since then.

Doctor Stewart is a member of the American Academy of Pediatrics, the American Medical Association, the American Heart Association and the American Public Health Association.

Members of the West Virginia State Medical Association who are interested in attending the April 10 dinner should contact Dr. G. Thomas Evans, 900 Locust Avenue, Fairmont, West Virginia.

'Good Samaritan' Law Now in Effect

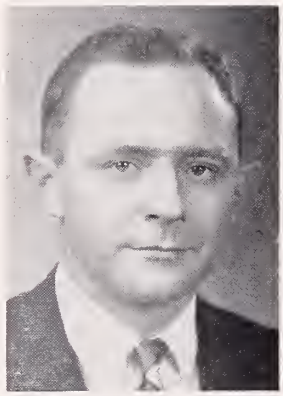
The "Good Samaritan" bill was signed into law on February 27 by Gov. Hulett C. Smith. It had been passed several days earlier by both the Senate and the House of Delegates by comfortable margins.

The new law provides that "no person, including a person licensed to practice medicine or dentistry, who in good faith renders emergency care at the scene of an accident, without remuneration, shall be liable for any civil damages as the result of any act or omission in rendering such emergency care."

The law is now in effect.

Doctor Blaydes to Present Paper in New York

Dr. J. Elliott Blaydes, Jr., of Bluefield, will be one of the speakers on ophthalmology at the annual New York Eye and Ear Infirmary Clinical Conference, which will be held at the Biltmore Hotel in New York City, April 10-11.



J. E. Blaydes, Jr., M. D.

Doctor Blaydes' topic will be "Cataract Surgery: Experience in 1700 Procedures."

Ophthalmology courses will be offered in applanation tonometry, tonography, gonioscopy, pediatric ophthalmology, management of ocular trauma, indirect ophthalmoscopy, ophthalmic pathology and cryosurgery.

All interested ophthalmologists and otolaryngologists are invited to attend. For registration and other information, contact Jane Stark, Registrar, New York Eye and Ear Infirmary, 218 Second Avenue, New York City, New York 10003.

Dr. Dyer Reports on Activities Of HIB Unit

In a recent issue of the "State of the State's Health," State Health Director N. H. Dyer reported the activities of the Health Insurance Benefits Unit which recently completed its first year of administering the Medicare program. The unit is basically concerned with certification, consultation and coordination in determining whether hospitals, extended care facilities, home health agencies, and independent laboratories meet and continue to meet certain standards to qualify for participation in the Health Insurance Program for the Aged, Doctor Dyer explained.

The health official reported 49 J. C. A. H. general hospitals with 7,479 beds and 31 non-J. C. A. H. general hospitals with 1,408 beds were certified making a total of 80 general hospitals with 8,887 beds certified. Four state psychiatric hospitals (selected areas only) with 489 beds and one private psychiatric hospital (not complete bed capacity) with 30 beds have been certified making a total of five psychiatric hospitals with 519 beds certified. One state tuberculosis hospital (selected area only) with 390 beds has been certified. Two state emergency hospitals with no beds listed have been certified. West Virginia's 88 certified hospitals with 9,796 beds compares favorably with the national average, Doctor Dyer remarked.

"When Extended Care Benefits became effective January 1, 1967, a new image was created for the nursing home, Doctor Dyer said. He explained that not all nursing homes will be participants; nor will all nursing homes be eligible.

"Extended Care Benefits under Medicare represents a special type of after-care which only certain types of skilled nursing homes will be able to provide," he said.

The HIB Unit has recommended certification for 15 extended care facilities in West Virginia with a total of 871 beds to date, Doctor Dyer explained. According to some information regarding the national average, he said, West Virginia is about 10 per cent above this average. Doctor Dyer noted that seven hospitals and one vocationally oriented rehabilitation center are interested in certifying a segment of the basic unit for extended care services. One of the seven has been certified for participation.

To date, Doctor Dyer said, 19 home health agencies have been certified to provide services. He explained most of the agencies have been established within county health units in the State although there is one hospital based home health agency and one such agency operating within a private home health center. Hopefully, he said, this is an area that will continue to develop throughout West Virginia.

It has been indicated that services home health agencies have to offer are not being fully utilized, Doctor Dyer commented, but, no doubt, there will be a greater demand for home health agency services when the program is better understood. The most common services being provided by home health agencies are skilled nursing, physical therapy, medical social services, speech therapy, and home health aides.

Originally the HIB Unit recommended certification for 30 laboratories thought to be in the category of independent laboratories, Doctor Dyer stated. Each was given "interim approval" to charge for services in approved areas. This number may be reduced considerably, he said, with new interpretations of independent laboratories that are being made by the Social Security Administration.

The Health Director commented that few problems have been experienced as far as carrying out the certification process. He said that perhaps this can be attributed to the understanding and cooperation of the people involved in the medical-health fields.

In another issue of the "State of the State's Health", Doctor Dyer reported that the 1967 revision of the Hill-Burton State Plan for Construction and Modernization of Hospital and Medical Facilities, revised annually by the State Health Department's Bureau of Hospitals and Medical Facilities, has advanced to the regional office of the U. S. Public Health Service and the Surgeon General of the U. S. Public Health Service for final approval after being approved by the State Advisory Council and the State Board of Health.

Required by the Federal Government before Hill-Burton funds can be allotted, the plan is drawn from formulae approved by the U. S. Public Health Service and is based on such factors as utilization, population distribution, the numbers of persons in various age groups, and the percentage of need met. If accepted, federal funds will be allocated by the State Board of Health for construction and modernization of hospital and medical facilities according to the priority of communities determined by the plan.

Federal funds are not allocated until an applicant submits an approvable program for construction and certifies that adequate financial resources for operating and for matching the Hill-Burton share of total costs are available.

In determining how federal funds are allocated, the state is divided into nine service areas. Each is assigned a priority based on relative need for construction and for modernization in the following categories: Hospitals and public health centers, long-term care facilities, modernization, rehabilitation facilities, and diagnostic and treatment centers.

In total, Doctor Dyer reported, the State needs 57 public health centers, to be added and 51 to be modernized or replaced; 58 long-term care facilities, 39 to be added and 6 to be modernized or replaced; 64 general hospitals, 3 to be added and 47 to be modernized or replaced; 11 rehabilitation facilities, 6 to be added and 1 to be modernized or replaced; 77 diagnostic or treatment facilities, 10 to be added and 42 to be modernized or replaced; and 1 tuberculosis hospital which is operating in Beckley. Mental Health facility programs are provided for under separate state plans.

New Jersey Medical Lists Meeting

The 201st Annual Meeting of The Medical Society of New Jersey will be held in Atlantic City, May 13-17.

Geriatrics Society Announces Grant Renewals

The American Geriatrics Society has renewed three $1,800 grants to encourage resident physicians to devote more time to the study of the medical problems of elder citizens.

The grants, inaugurated by Lederle Laboratories in 1962, will supplement the salaries the physicians receive. They will cover the period July 1967 to June 1968.

Applications for the grants should be addressed to the Chairman, Fellowship Committee, American Geriatrics Society, 10 Columbus Circle, New York City, New York 10019. The deadline for applications is June 1, 1967, and announcement of the recipients will be made at the Society's annual meeting in Atlantic City, New Jersey, June 16-17.

Health Fair in Charleston September 22-24

The Kanawha Medical Society and the Community Council of the Kanawha Valley will co-sponsor a Health Fair at the Civic Center in Charleston, September 22-24.

Mr. Bill Boyd of the West Virginia Division of Vocational Rehabilitation has been named chairman of the event.

Mr. Boyd said he expects 35 to 50 agencies to participate. A similar Health Fair two years ago drew more than 10,000 adults.

Five-Day Cardiology Course Scheduled in Atlanta

A five-day postgraduate course entitled "Cardiology Today" will be presented in Atlanta, Georgia, May 8-12.

The course is sponsored by the Council on Clinical Cardiology of the American Heart Association and the Department of Medicine of the Emory University School of Medicine in cooperation with the Georgia Heart Association.

The registration fee will be $85.00 for Fellows and Members of the Council on Clinical Cardiology and $125.00 for nonmembers.

Additional information may be obtained by writing to Mrs. Lorraine Kreiner, Council on Clinical Cardiology, American Heart Association, 44 East 23rd Street, New York City, New York 10010.

Change of Address

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Emergency Care Course At Marshall U.

A practical course on emergency aid and transportation of critically ill and injured persons will be held at Marshall University in Huntington, April 13-15, under the sponsorship of the Committee on Injuries of the American Academy of Orthopaedic Surgeons.

James A. Heckman, M. D.

The three-day course of lectures and demonstrations is open to safety engineers, ambulance attendants, policemen, firemen, and public health, civil defense and other officials dealing with the initial handling of emergency patients. Registrants are expected from West Virginia, Pennsylvania, Ohio and Kentucky.

Cooperating with the Academy in the program are Marshall University, the Tri-State Fire School and the Cabell County Medical Society. Dr. James A. Heckman of Huntington is Chairman of the Program Committee for the Course.

"It is well established that a fast ride by ambulance is not essential in getting the injured to a hospital," Doctor Heckman said. "What is really needed is an emergency crew well trained in the preparation of the injured for transport."

Lectures and demonstrations will cover such subjects as resuscitation, cardiac massage, splinting of fractures, burns and other medical emergencies.

Physicians representing orthopedic and other medical and surgical specialties will speak, as well as an attorney and officials of the Huntington Fire Department.

The registration fee of $35.00 will include lunches.

The course is one of a series being conducted in major cities by the Academy's Committee on Injuries. Similar courses are to be given this year in New York; New Orleans; Portland, Oregon; Boston and Miami.

Additional information may be obtained by writing to Dr. James A. Heckman, 1032 Sixth Avenue, Huntington, West Virginia 25701.

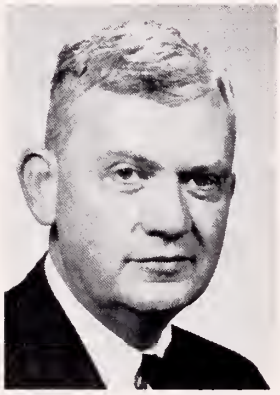
BS Serving 70 Million People

The National Association of Blue Shield Plans reports that almost 70 million persons are now being served by BS plans in the United States, Canada and Puerto Rico.

Enrollment in those three countries in 84 BS plans is now more than 59,145,000. An additional 10.7 million persons are served by BS under various government programs, including Titles 18 and 19 of Medicare, medical care for military dependents and welfare programs.

43rd State Health Conference In Charleston, May 11-12

The West Virginia Public Health Association will sponsor its 43rd Annual State Health Conference at The Daniel Boone Hotel in Charleston, May 11-12.



Edward G. Stuart, M. D.

Theme of the session, arranged in cooperation with the State Health Department, is "New Sights for New Progress."

The highlight of the program will be a Viral Disease Seminar with emphasis on Rubella conducted by the U. S. Public Health Service Thursday morning, May 11.

The seminar will entail basic concepts of viral infections including the classification and biologic relationships of animal viruses, morphology of viruses, physicochemical properties of viruses, viral genetics, viral multiplication, pathology of virus infections, and laboratory propagation of viruses; immune response including antigenic composition of viruses, mechanism of antibody production, antibody assay procedures, action of antibodies of viruses, the role of the antibody in natural viral infection, "cellular" aspects of antiviral defense, immune tolerance in viral infections, and non-specific immune mechanisms; an epidemiological approach to Rubella, and diagnostic services including principles of laboratory confirmation, rapid diagnosis, and available laboratory facilities.

Dr. Edward George Stuart, Vice President of the West Virginia University Medical Center, and Bertlyn Bosley, Ph. D., nutrition adviser, Pan-American Health Organization, Pan-American Sanitary Bureau, Regional Office of the World Health Organization, Washington, D. C., will speak at the Friday morning general session.

Afternoon sessions will consist of section meetings.

The annual president's reception and banquet is scheduled for Thursday evening followed by the presentation of awards honoring two persons contributing to the field of public health.

Cleveland Clinic Lists Year's Last Programs

April courses in gastroenterology and diabetes will bring the 1966-67 schedule of postgraduate courses sponsored by the Cleveland Clinic Educational Foundation to a close.

The Foundation will sponsor a course on "Diagnostic Procedures in Gastroenterology" on April 5-6, and one on "Diabetes Mellitus: The Old and the New" on April 26-27.

Additional information may be obtained by writing to the Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1967

April 3-5—Am. Acad. of Ped., San Francisco.
April 7-9—Am. Soc. of Int. Med., San Francisco.
April 10-13—Indus. Med. Assn., New York City.
April 10-14—Am. Col. of Physicians, San Francisco.
April 11-13—Am. Surg. Assn., Colorado Springs.
April 13-15—W. Va. Chap., ACS, White Sulphur Springs.
April 17-20—Am. Col. of Ob. and Gyn., Washington.
April 17-19—Am. Assn. for Thoracic Surgery, New York.
April 19-21—Maryland Medical, Baltimore.
April 23-26—W. Va. Acad. of Oph. and Otol., White Sulphur Springs.
April 24-29—Am. Acad. of Neurology, San Francisco
April 24-26—AMA Nat. Cong. on Environment Health Management, New York City.
April 27-28—Am. Ped. Soc., Atlantic City.
April 28-30—W. Va. Chapter, AAGP, Huntington.
April 30-May 5—Int. Col. of Surgeons, Bal Harbour, Fla.

May 2-3—Assn. of Am. Phys., Atlantic City.
May 3—Am. Cancer Soc., Dallas.
May 4-6—Am. Gynecological Soc., Phoenix.
May 6—Am. Col. of Psychiatrists, Philadelphia.
May 7-12—Am. Psy. Assn., Detroit.
May 11-14—Am. Surg. Assn., Colorado Springs.
May 16-19—Ohio Medical, Columbus.
May 28-June 1—Am. Dermatological Assn., Colorado Springs.
May 29-31—Am. Oph. Soc., Hot Springs, Va.
May 29-June 1—Am. Urol. Assn., New York.
May 21-24—Am. Thoracic Soc., Pittsburgh.

June 15-16—Am. Rheumatism Assn., New York City.
June 15-17—Am. Col. of Chest Phys., Atlantic City.
June 16-17—Am. Geriatrics Soc., Atlantic City.
June 17—Acad. of TB Phys., Atlantic City.
June 17-18—Am. Diabetes Assn., Atlantic City.
June 18-22—AMA Annual Con., Atlantic City.
June 22—Annual Preston County Meeting, Kingwood.

June 26-29—Am. Orthopaedic Assn., Hot Springs, Va.
July 14-15—Rocky Mtn. Cancer Conf., Denver.

July 23-29—Sou. Seminar in Ob. & Gyn., Asheville, N. C.

Aug. 21-24—Am. Hosp. Assn., Chicago.
Aug. 24-26—100th Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.

Aug. 27-Sept. 1—Am. Acad. of Phys. Med. & Rehab., Miami Beach.

Sept. 7-9—Am. Assn. of Ob. and Gyn., Hot Springs, Va.
Sept. 15-23—AAGP, Dallas.
Sept. 22-29—Col. of Am. Pathologists, Chicago.
Sept. 26-28—Ky. Medical, Louisville.
Sept. 27-30—Penn. Medical, Philadelphia.
Sept. 29-Oct. 1—W. Va. Heart Assn., Wheeling.
Sept. 29-Oct. 3—Am. Soc. of Anes., Las Vegas.

Oct. 2-6—ACS, Chicago.
Oct. 19-21—Va. Medical, Alexandria.
Oct. 20-24—Am. Heart Assn., San Francisco.
Oct. 21-26—Am. Acad. of Ped., Washington.
Oct. 29—Am. Assn. of Oph., Chicago.
Oct. 29-Nov. 3—Am. Acad. of Oph. and Otol., Chicago.

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County Societies

CABELL

The regular monthly meeting of the Cabell County Medical Society was held at The Hotel Frederick in Huntington on January 12 with 38 members present.

The retiring President, Dr. Joseph Farrell, reviewed the programs during 1966 and discussed Medicare and its effect on medicine. He then yielded the chair to his successor, Dr. William L. Neal.

The Society approved an assessment of $10 per member and a contribution of $150 for the Marshall University Science Fair.—Harold N. Kagan, M. D., Secretary.

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MARION

Mr. Harry F. Walker, Executive Director of the West Virginia Commission on Aging, was guest speaker at a recent joint meeting of the Marion County Medical Society and its Woman's Auxiliary at the Fairmont Hotel in Fairmont.

Mr. Walker's topic was "Why We Have an Aging Problem and What We Are Trying To Do About It."

Mrs. James Wotring, President of the Auxiliary, presided at the meeting.

Dr. David Bressler, President of the Medical Society, introduced Dr. and Mrs. R. H. Jones, Jr., and Dr. and Mrs. Robert J. Gardner, new members of the Society and Auxiliary.

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MERCER

The regular monthly meeting of the Mercer County Medical Society was held at the West Virginian Hotel in Bluefield on January 16.

Dr. R. R. Raub of Bluefield gave an interesting account of his recent safari to India.

Dr. Upshur Higginbotham gave a report on the work of the State Medical Association's Committee on Medical Education and Hospitals, of which he is a member.—John J. Mahood, M. D., Secretary.

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McDOWELL

Dr. Frank C. Gazzaniga of Stevens Clinic presented the scientific program at the regular monthly meeting of the McDowell County Medical Society which was held on January 11.

Dr. John H. Murry presented a report on the West Virginia Health Department Bureau of Public Health Nursing and Home Nursing Care serving McDowell County.

Twelve members and five guest physicians attended the meeting.

Dr. Ray E. Burger presented the scientific program at the February 8 meeting of the McDowell County Medical Society which was held at Grace Hospital.

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He presented films on "Vineberg Procedure" and "The Obsolete Menopause."

Dr. A. J. Villani read a report from Dr. Upshur Higginbotham of Bluefield concerning the work of the State Medical Association's Committee on Medical Education and Hospitals.

Twelve members and five guests attended the meeting.—Joseph C. Ray, M. D., Secretary.

★ ★ ★ ★

MONONGALIA

Dr. John B. Harley of Morgantown presented the scientific program at the regular monthly meeting of the Monongalia County Medical Society, which was held on January 3 with 35 members and two guests attending.

Doctor Harley's topic was "Multiple Myeloma." A series of cases from West Virginia University Hospital were discussed and the clinical findings and therapeutic results were given.—Robert Greco, M. D., Secretary.

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Woman's Auxiliary

to the

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President Elect: Mrs. Rupert W. Powell, Fairmont
First Vice President: Mrs. Robert J. Tchou, Williamson
Second Vice President: Mrs. C. B. Buffington, Wheeling
Third Vice President: Mrs. Richard G. Starr, Beckley
Fourth Vice President: Mrs. Robert W. Bess, Jr., Westernport, Md.
Treasurer: Mrs. J. Dennis Kugel, Charleston
Recording Secretary: Mrs. Joe N. Jarrett, Oak Hill
Corresponding Secretary: Mrs. William T. Lawson, Fairmont
Parliamentarian: Mrs. D. E. Greeneltch, Wheeling

MINGO

Mrs. Hu C. Myers of Philippi, President of the Woman's Auxiliary to the West Virginia State Medical Association was guest speaker at a meeting of the Auxiliary to the Mingo County Medical Society which was held in Williamson in January.

Mrs. Myers praised the local Auxiliary for its active participation in community work and in promoting various projects undertaken by the Auxiliary at the local and state levels.

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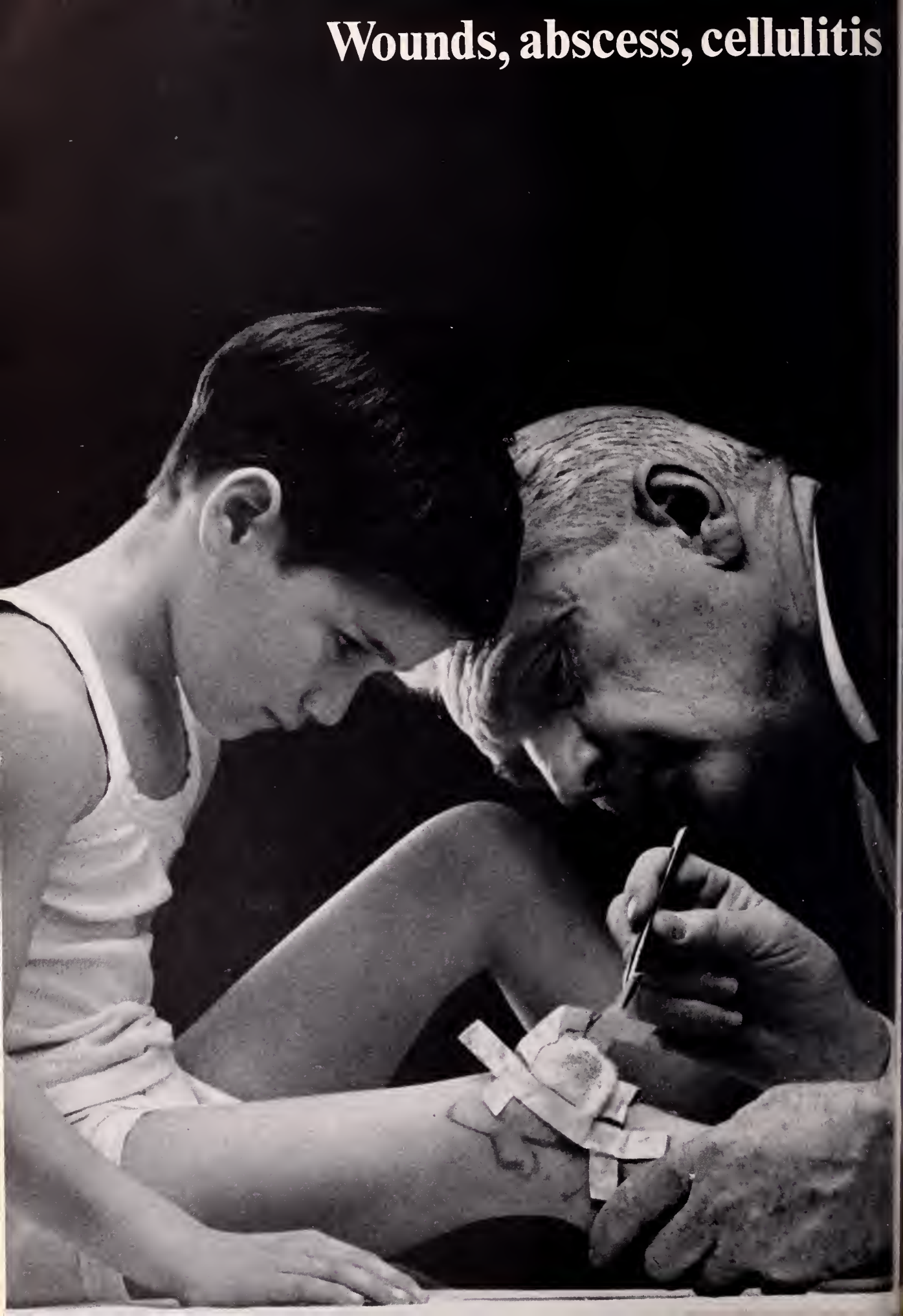


MERCER

Dr. James P. Thomas was guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Mercer County Medical Society which was held in Bluefield in January.

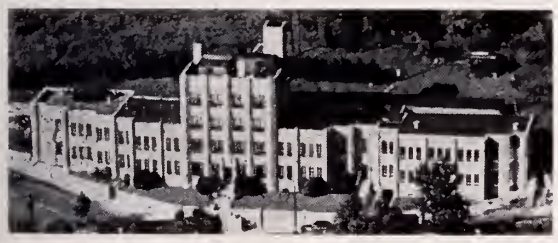
Doctor Thomas discussed the surgical aspects of heart disease. He showed slides with his lecture and conducted a question-and-answer session.

PMA Chief Predicts Battle On Generic Issue

Mr. C. Joseph Stetler, President of the Pharmaceutical Manufacturers Association, predicts that a battle over a proposal for compulsory generic prescribing of drugs will help mark an important new stage in relations between the government and the nation's health team.

In a speech at the 1967 Conference on Legislation of the Texas Medical Association, Stetler warned that what he termed the harassment and the pressure for government regulation and control which have been directed at the prescription drug industry in the past will now be turned on physicians, drug wholesalers and pharmacists.

Pharmacists would be required under the measure to dispense so-called generic drugs regardless of whether the physician orders a specific brand or designates the product of a particular manufacturer.



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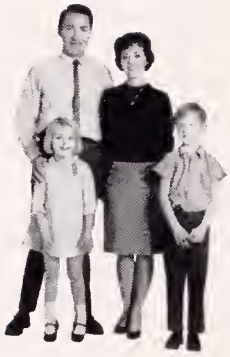

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1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.

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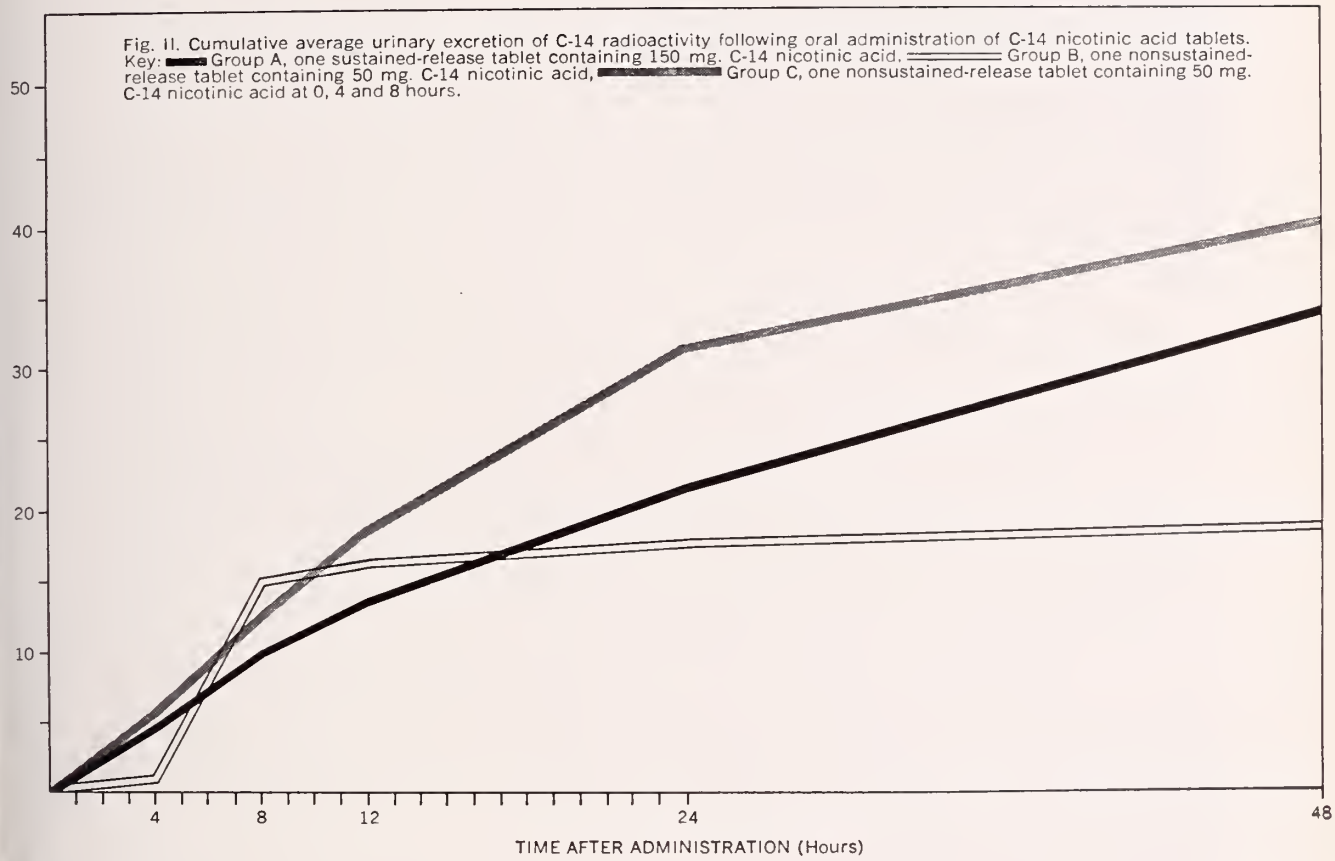

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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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American Acad. of Pediatrics Slates Spring Session

More than 3,000 pediatricians, their families and guests will attend the annual spring session of the American Academy of Pediatrics in San Francisco, April 3-5.

The meeting will feature closed-circuit television clinical presentations, a diversified scientific program, and more than 120 scientific and technical exhibits.

The scientific program will focus on child health in contemporary American society, the newborn, neurologic disorders, the child from two to six years of age, and school difficulties.

Television presentations will originate at Presbyterian Medical Center and can be seen at the San Francisco Hotel. Televised subjects will include brain tumors, dermatologic disease in the young child, the eye examination, oral biology, and venomous animal injuries.

Additional information may be obtained by writing to the American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Illinois 60204.

Pittsburgh Hospital Seeks Radiology Trainees

Allegheny General Hospital of Pittsburgh is offering an opportunity for training in radiation therapy.

The position leads to board certification and is open to general practitioners, physicians with training in internal medicine, pathology and allied specialties. Salary is commensurate with number of dependents, age and experience.

Additional information may be obtained by writing to Dr. John Frich, Department of Radiation Therapy, Allegheny General Hospital, Pittsburgh, Pennsylvania 15212.

PG Course in Adrenal Diseases

A postgraduate course entitled "The Adrenals Revisited" will be conducted at the Medical College of Georgia in Augusta, April 20-21.

The program will be presented by the Medical College, the Medical Association of Georgia and the Georgia Academy of General Practice. The American Academy of General Practice has assigned 14 hours of credit to the course.

The course is designed to present current concepts on the recognition and management of diseases and therapeutics involving the adrenal glands. Five guest teachers will join the Medical College faculty in presenting the program.

A registration fee of $30 will be charged, with interns and residents exempt.

Additional information may be obtained by writing to the Department of Continuing Education, Medical College of Georgia, Augusta, Georgia 30902.

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1. Carson, M., and Hart, L.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," Colloquim held under the auspices of The Pediatric Department, Western Reserve University School of Medicine at Cleveland, Ohio, Sept. 8, 1966. Data available on request.

2. Hepner, R.: ibid. 3. Nichols, M.: ibid. 4. McCann, M.L.; Teree, T., and Wallace, W.; ibid.

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WVU Medical Center
—News—

A residency program in dermatology will be offered at the Medical Center beginning July 1. The program has been approved by the American Medical Association and the American Board of Dermatology.

Supervising the new program will be Dr. William Welton, Associate Professor and Chairman of the Division of Dermatology.

One applicant will be accepted each year for the 12-month program.

Doctors Sleeth and Flink Honored

Two officials of the School of Medicine were among 12 distinguished professors of WVU who were selected by their colleagues to be honored at the 100th Anniversary Faculty Honors Convocation on March 7.

They are Dr. Clark K. Sleeth, Dean of the School of Medicine, and Dr. Edmund B. Flink, Chairman of the Department of Medicine.

Surgical Society Elects Dr. Moran

Dr. Walter H. Moran, Jr., Associate Professor of Surgery, has been elected to the Society of University Surgeons.

Doctor Moran was elected at a meeting of the Society in Toronto, February 9-11. He is the fifth WVU surgeon now a member of the Society, which limits its membership to 200 surgeons from the United States and Canada. The other WVU members are Drs. Byron Bloor, Herbert Warden, Alvin Watne and Bernard Zimmermann.

Doctor Moran joined the School of Medicine in 1960. He is noted for research concerning chemical changes in the body related to surgical operations and for development of a number of methods for studying hormones.

Second Semester Enrollment

Enrollment figures for the second semester show the School of Medicine has the largest number of students on the Medical Center campus.

There are 231 medical students, including 62 first year, 57 second year, 59 third year and 53 fourth year.

The School of Dentistry has 189 students, while the Schools of Nursing and Pharmacy each have 123 students enrolled for the second semester.

The Division of Dental Hygiene has 70 students, and the Division of Medical Technology, 44. There are 95 graduate students studying at the Medical Center.

Anatomists Present Papers

School of Medicine faculty members will present four papers at the meeting of the American Association of Anatomists in Kansas City, April 4-8.

Dr. Donald L. Kimmel, Chairman of the Department of Anatomy, will deliver a paper on "The Central Distribution of Sensory Trigeminal Nerve Fibers" in cooperation with two members of the faculty of the University of Chicago School of Medicine.

Dr. Paul Benoit, Assistant Professory of Anatomy, will deliver a paper on "The Electron Microscopy of the Endothelium of the Aorta of the Guinea Pig."

Dr. David S. Jones, Professor of Anatomy, and three first-year medical students, will present a paper on "An Unusual Thyroid Artery in the Human."

Dr. Randall Reyer, Associate Professor of Anatomy, will read a paper on "Lens Regeneration Following Removal of the Lens Alone or After Removal of the Lens and Neural Retina. DNA Synthesis and Lens Capsule Differentiation."

• Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.

Cancer Teaching Day

The Third Annual Cancer Teaching Day program will be held at the Medical Center, April 21-22, with Dr. Danely P. Slaughter serving as the principal speaker.

Doctor Slaughter, Clinical Professor of Surgery at the University of Illinois and Chief of Surgery at St. Francis Hospital in Evanston, Illinois, will present two papers concerning the problems of head and neck cancer.

Other speakers will include the following members of the School of Medicine Faculty: Dr. George G. Green, Associate Professor of Radiology; Dr. Alvin L. Watne, Associate Professor of Surgery; Dr. Barbara Jones, Associate Professor of Pediatrics; Dr. Richard C. Juberg, Assistant Professor of Pediatrics; Dr. Jerome G. Johnson, Resident in Surgery; Dr. John L. Campbell, Professor of Oral Surgery; and Dr. Philip Sprinkle, Associate Professor of Surgery and Chairman of the Division of Otolaryngology.

Sponsors of the program are the West Virginia Division of the American Cancer Society, the Charleston Foundation for Cancer Research at WVU, and the Cancer Committee of the West Virginia State Medical Association.

Research in Pancreatitis

Original research in pancreatitis, particularly the relationship of alcohol to its occurrence, is being conducted at the Medical Center.

Dr. Jorge Cueto, Resident in Surgery and one of the investigators, reported results obtained so far at a combined meeting of the Society of University Surgeons and the British Society of Surgical Research in Toronto in February.

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E. E. Gimenez, M. D.

Mental Health Clinic
Professional Building, Wise, Va.
Pierce D. Nelson, M. D.

The Month in Washington

• From the Washington Office of the American Medical Association.

THE Department of Health, Education and Welfare stated in a special report that both hospital charges and physicians' fees increased sharply last year. A continued increase in health care costs was predicted in the report ordered last August by President Johnson.

Drugs were not a significant factor in the recent accelerated increase in health care prices, the report said. But it added that "drug prices are higher than they would be if there were more vigorous competition at either the manufacturing or drugstore level,"

As for the two major components in the Medical Care Index, the report said:

—Physicians' fees, which had been rising about three per cent a year in 1960-65, went up 7.8 per cent in 1966—the biggest annual increase since 1927.

—Hospital daily charges, rising about six per cent a year between 1960 and 1965, went up to 16.5 per cent in 1966—the largest annual increase in 18 years.

The increase in doctor fees was attributed to a combination of basic factors: "more people are seeking doctors' services more often and the number of active physicians is increasing relatively slowly." The study found no evidence that Medicare, which went into effect last July 1, was a major factor in the rise in doctors' fees.

The increase in hospital charges was attributed largely to rising wages, which account for two-thirds of hospital costs, and increases in the price of things hospitals buy. The wage rise has not been off-set by increased productivity, the report said, and rising standards of care in hospitals have required more expensive equipment and facilities.

Meantime, Robert J. Myers, the Social Security Administration's chief actuary, told the House Ways and Means Committee, that hospital costs had risen much faster than the Administration anticipated since the Medicare plan went into effect. If they continue their upward spiral, the costs will eat away the safety margin included under the Medicare financing plan, Myers said.

Recommended Series of Actions

The HEW report held out little hope for an early end to medical price increases. However, it recommended a series of actions "to slow down these increases and to promote the efficient use of medical care resources."

Recommendations in the report included:

—Comprehensive community health care systems should be developed, demonstrated, and evaluated.

—Group practice, especially prepaid group practice, should be encouraged.

—Private and public health insurance plans should be broadened to include more alternative types of medical care.

—States should move quickly to establish and support strong health planning agencies at the state and local levels.

—Cost-reducing methods of reorganizing the delivery of services in hospitals and other providers of health services should be developed, demonstrated, and implemented.

—Federally supported health care programs should be used to train physician assistants, evaluate their performance, and disseminate the results.

—Federal funds available under the Health Professions Educational Assistance Amendments of 1965 should be used to support and encourage innovations in health professions, education and training which promote the efficient practice of medicine.

—HEW should undertake an intensive examination of frequently prescribed drugs to assess the therapeutic effectiveness of brand name products and their supposed generic equivalents.

—The Food and Drug Administration should provide doctors with authoritative information of the efficacy and side effects of all drugs.

To carry out the recommendations in the report and allied directives from Johnson, HEW Secretary John W. Gardner said he would take a number of actions, including establishment of a National Center for Health Services Research and Development and calling of a national conference on medical care costs.

Hearings on Hart Bill

The American Medical Association contends there is not sufficient justification for a federal law that would ban dispensing of drugs and devices, such as eyeglasses, by physicians.

Dr. James Z. Appel, Immediate Past President of the AMA, outlined the AMA position in testimony before the Senate Antitrust and Monopoly Subcommittee which helds hearings on such legislation (S. 260) introduced by its chairman, Sen. Philip A. Hart (D., Mich.).

The legislation appeared to stand little chance of being approved by Congress, at least this year. Senator Hart has unsuccessfully pushed similar legislation for the past few years.

The AMA believes that "federal legislation cannot be justified unless there is a compelling need," Doctor Appel testified. In this case, he said, "such a need does not exist."

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Obituaries

HERMAN LEON HEGNER, M. D.

Dr. Herman L. Hegner, 63, of Wellsburg, died on February 23.

A native of Pittsburgh, Doctor Hegner received his M. D. degree in 1931, from New York University. He served his internship at All Souls Hospital in Morristown, New Jersey, and had been engaged in surgery and general practice in Wellsburg for 32 years.

He served as a medical officer during World War II and was a member of the Brooke County Medical Society, the West Virginia State Medical Association, the American Medical Association, and the West Virginia Chapter of the American Academy of General practice. He was a Past President of his local medical society.

Survivors include the widow; three daughters, Mrs. Ronald J. Dunlavey of Washington, D. C., Mrs. John J. O'Herron of Newburgh, New York, and Mrs. William Chesson, Jr., of Steubenville, Ohio; a son, Capt. H. L. Hegner, Jr., of Shaw Air Force Base, South Carolina; three sisters; one brother and 13 grandchildren.

★ ★ ★ ★

STANLEY JAMES KLYZA, M. D.

Dr. Stanley J. Klyza of Washington, D. C., formerly of Clarksburg, died in a Washington hospital on February 14.

An obstetrician, Doctor Klyza had just finished a delivery when he collapsed. He died about 10 minutes later.

Born in 1911, in Clarksburg, Doctor Klyza attended West Virginia University and received his M. D. degree from the University of Chicago School of Medicine in 1938. He was a former member of the Harrison County Medical Society and the West Virginia State Medical Association.

During 1935-37, he was a member of the faculty of the West Virginia University School of Medicine, and during 1942-46, he held the rank of Lieutenant Commander in the Medical Corps of the United States Navy. He served in both the Atlantic and Pacific operations.

Survivors include the widow; two sons, Stanley D. and Mark A. Klyza; his father, Andrew Klyza; two brothers, Aloysius Klyza of Ohio and Bernard Klyza of New York; three sisters, Mrs. Amelia Zywinski of New Jersey, Mrs. Albina Smith of Pennsylvania, and Mrs. Regina Lasho of New Jersey.

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HENRY MACHMER, M. D., D. D. S.

Dr. Henry Machmer of South Charleston died on February 27 in a Charleston hospital. He was 63.

Doctor Machmer was born in Yugoslavia and received his M. D. degree in 1932 from the University of Vienna. He also earned a degree in dentistry from a college in his native Yugoslavia.

He came to the United States from Austria in 1952. He was a member of the Kanawha Medical Society,

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the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; a daughter, Mrs. August Zimmerman of Lancaster, Ohio; a son, John, of Washington, D. C.; and grandchildren.

★ ★ ★ ★

MORRIS ISADORE MENDELOFF, M. D.

Dr. Morris I. Mendeloff of Charleston died in a hospital in Baltimore, Maryland, on February 15 at the age of 79.

Doctor Mendeloff came to the United States from his native Russia in 1906. He received his M. D. degree in 1912 from the College of Physicians and Surgeons in Baltimore. He took postgraduate work at Harvard Medical College and specialized in internal medicine.

Doctor Mendeloff was a Past President of the Kanawha Medical Society and was a member of the West Virginia State Medical Association, the American Medical Association, the American College of Physicians and the Southern Medical Association.

During World War I, he served as an Army Surgeon in Europe.

Survivors include the widow, Mrs. Esther Mendeloff; two sons, Dr. Morris Mendeloff, Jr. of Charleston, and Dr. Albert Mendeloff of Baltimore; a daughter, Mrs. Lillian Eisman of Frederick, Maryland, brothers Herman of Philadelphia and Harry of Chicago; and eight grandchildren.

NEWMAN H. NEWHOUSE, M. D.

Dr. Newman H. Newhouse, a Charleston anesthesiologist, died in his sleep at his home on March 15. He was 57.

A native of Wayne County, Doctor Newhouse attended Marshall University. He also attended the two-year WVU School of Medicine and received his M. D. degree in 1936 from the University of Louisville School of Medicine.

For many years, Doctor Newhouse was engaged in general practice in Charleston. He studied anesthesiology at Reading Hospital in Pennsylvania and practiced that specialty in recent years. He was Chief of the Department of Anesthesiology at McMillian Hospital in Charleston.

During World War II, Doctor Newhouse served as a Medical Officer in the United States Navy and was discharged in 1945 with the rank of Lieutenant Commander.

His professional memberships included the Kanawha Medical Society, the West Virginia State Medical Association, the American Medical Association, and the West Virginia Society of Anesthesiology, of which he served two terms as President.

Survivors include the widow; a son, Richard H. Newhouse, who is in the Navy stationed at Great Lakes, Illinois; and a daughter, Julia Evelyn Newhouse, a student in Cincinnati.

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County Societies

CABELL

Dr. Peter Halmos of the Department of Medcine of the West Virginia University School of Medicine was guest speaker at the regular monthly meeting of the Cabell County Medical Society, which was held at the Hotel Frederick on February 9.

Doctor Halmos' topic was "Cardiomyopathies." Considerable discussion followed presentation of the paper.

The Society decided to continue its annual Symposium for at least two or three more years.

Thirty-six members and guests attended the meeting.—Harold N. Kagan, M. D., Secretary.

* * * *

MERCER

Dr. Amos Johnson of Garland, North Carolina, was guest speaker at the regular monthly meeting of the Mercer County Medical Society which was held at the West Virginian Hotel in Bluefield on February 20.

Doctor Johnson gave an interesting talk on practicing medicine and the increasing role of the Federal Government in medical practice. Among other things, he discussed the high cost of hospitalization.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

The regular monthly meeting of the Monongalia County Medical Society was held in Morgantown on February 2 with 30 members present.

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, was scheduled to be guest speaker, but a snowstorm prevented him from attending. Dr. Richard A. Currie filled in with an impromptu account of the medical problem in Vietnam, where he served as a volunteer physician for two months.—Robert Greco, M. D., Secretary.

20th Anniversary Meeting Of Blood Bank Assn.

The 20th Anniversary Meeting of the American Association of Blood Banks will be held at the Americana Hotel in New York City, October 21-25.

Abstracts for papers to be read at the scientific and administrative sections are being accepted through June 1. Forms for submitting abstracts may be obtained from the American Association of Blood Banks, Suite 1322, 30 North Michigan Avenue, Chicago, Illinois 60602.

Heart Council Meeting in October

The 1967 Annual Meeting of the American Heart Association's Council on Arteriosclerosis will be held in San Francisco, October 18-19, immediately preceding the Association's annual three-day scientific session.

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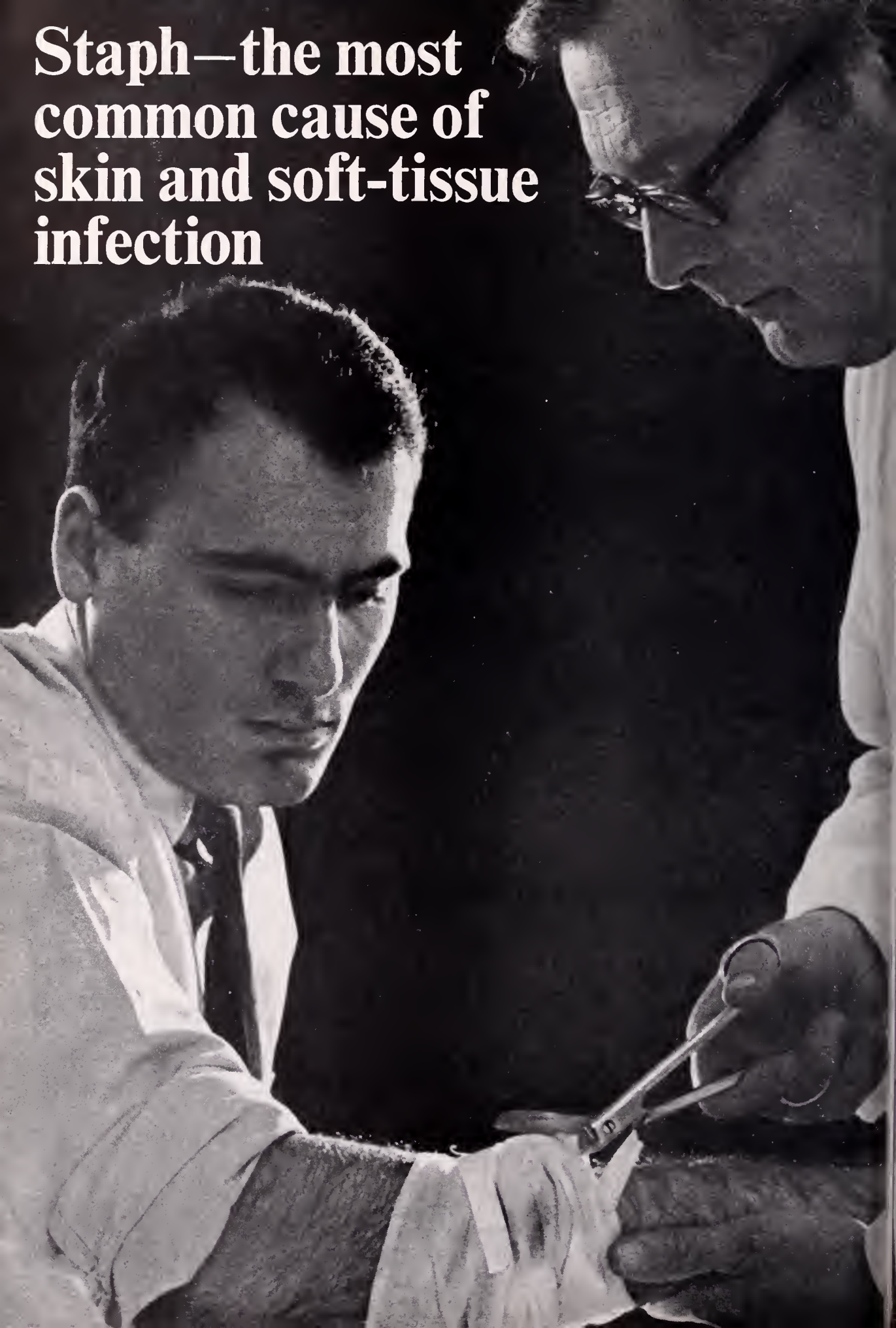

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KANAWHA

The Woman's Auxiliary to the Kanawha Medical Society held a luncheon meeting at The Daniel Boone Hotel in Charleston on February 14.

Out-of-town guests for the meeting included Mrs. M. Bruce Martin of Huntington, AMA-ERF Chairman of the Woman's Auxiliary to the West Virginia State Medical Association, and Mrs. Richard G. Starr of Beckley, Third Vice President of the State Auxiliary.

Members of the Kanawha Auxiliary served as models for a special hat show presented by a Charleston department store.

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Surgery:
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WOMAN'S AUXILIARY—(Continued)

The Auxiliary voted to allocate almost $2,000 from its Special Projects Fund for the following programs: State Health Careers, $100; Morris Harvey College School of Nursing, $900; hearing and testing for school children, $600; Kanawha County Clothing Chest, $200; Camp Galahad, $100; and AMA-ERF, $92.85.—Mrs. H. A. Jackson, Publicity Chairman.

* * * *

MARION

The Woman's Auxiliary to the Marion County Medical Society held a dinner meeting in Fairmont on February 28 with Marion County school counselors as guests.

The program was presented by Mrs. John D. Lindsay, Jr., Health Careers Chairman. She used slides to illustrate her talk.

Mrs. James Wotring, President, presided, and introduced Mrs. Hu C. Myers, President of the Woman's Auxiliary to the West Virginia State Medical Association.

* * * *

RALEIGH

Dr. Asa Barnes of Beckley, Area Medical Administrator of the United Mine Workers Welfare and Retirement Fund, was guest speaker at the February luncheon meeting of the Woman's Auxiliary to the Raleigh County Medical Society.

Doctor Barnes described regulations and procedures governing the fund and praised Beckley area physicians and hospitals for their cooperation with the Fund.

Mrs. Everett B. Wray, Jr., President of the Auxiliary, announced that the Raleigh Auxiliary will be in charge of a dance planned as a part of the Centennial Meeting of the State Medical Association at The Greenbrier in August.

Drug Prices Are Falling, PMA Says

The Pharmaceutical Manufacturers Association, quoting statistics from the U. S. Department of Labor, said in a recent statement that prescription drug prices declined during 1966.

The Labor Department's consumer price index for prescriptions reached a new average low of 90.6 for 1966, nine per cent below that for the 1957-59 base period, according to PMA. The drop was attributed to price reductions for anti-infective, tranquilizing and anti-arthritic medications.

"The trend of prescription drug prices is definitely down," PMA President C. Joseph Stetler, observed. "If drug prices had followed the course of the government's 'all-item' index, the cost of drugs bought in 1966 would have been nearly 25 per cent higher."

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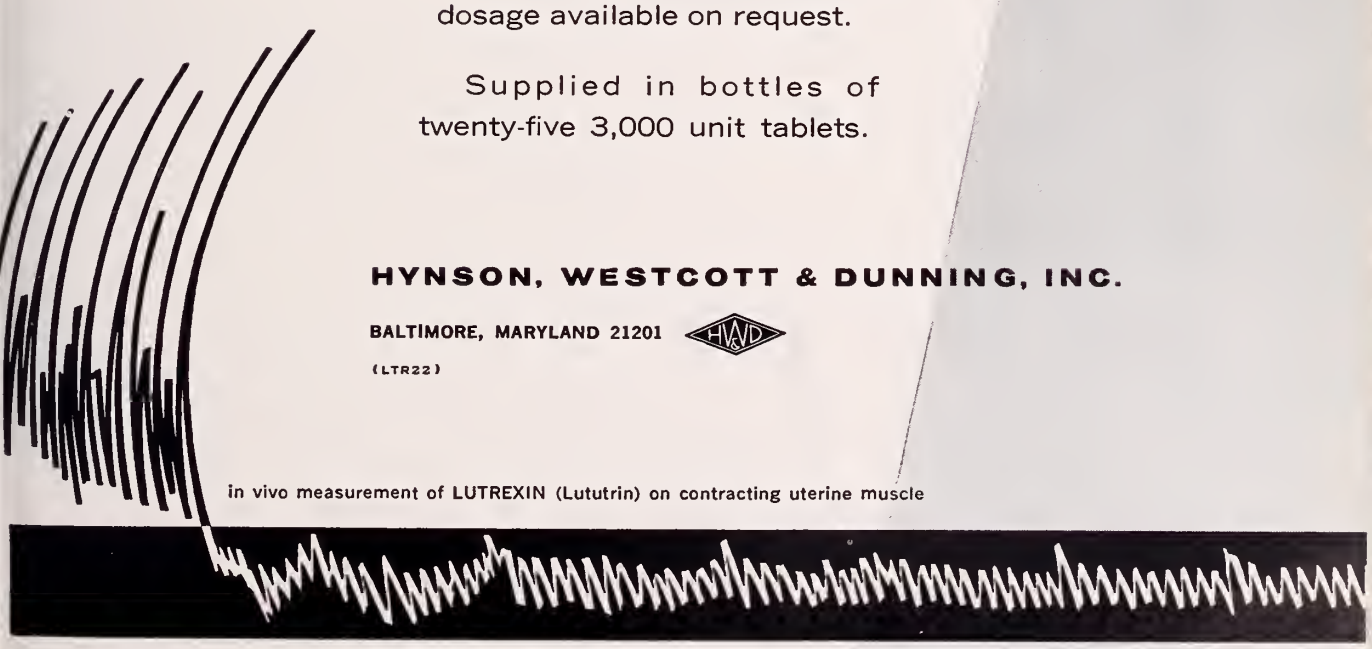

MAY
1967

Vol. 63 No. 5

The
WEST VIRGINIA
Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston, W. Va. 25324

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50c per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

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The West Virginia Medical Journal

Vol. 63, No. 5 May, 1967

Progress in the Treatment of Childhood Leukemia*

Barbara Jones, M. D.

Although acute leukemia remains a fatal disease, intensive treatment of children with acute lymphocytic leukemia by the use of chemotherapeutic agents and appropriate adjuvant measures has in recent years resulted in a significant prolongation of life as well as long asymptomatic periods. Between 1953 and 1961, the median survival period of these patients was eight to ten months;[1] but by 1966, 50 per cent were living 16 to 18 months.[2,3] Unfortunately, similar progress in the management of acute myelocytic leukemia has not been made.

In view of the above-mentioned encouraging data, evaluation of the length of survival of children with acute leukemia at West Virginia University Hospital, on the Pediatric Service, and as reported to the West Virginia Central Cancer Registry was made. Factors contributing to the improvement in survival are discussed in this paper.

Results

From the beginning of 1960 through 1965, 81 cases of acute leukemia were diagnosed. Of this number, 74 were reported to the West Virginia Central Cancer Registry and an additional seven patients who were from outside the state were seen at WVU Hospital. Table 1 divides the incidence into two three-year periods, that is, 1960 through 1962 and 1963 through 1965. All patients seen at WVU Hospital whose cases also were reported to the Cancer Registry are included only in the former group.

Of the 81 cases, 58 were diagnosed as acute lymphocytic leukemia and 23 as acute myelocytic leukemia. The 28 per cent incidence of acute myelocytic leukemia is higher than the 10 per cent to 15 per cent incidence generally reported in children but an explanation of the high incidence is not readily apparent. In the case of those patients seen at WVU Hospital, the morphologic diagnosis was made by the writer and in the remaining cases the diagnosis as reported to the Cancer Registry was accepted without attempt at verification.

Following the same subdivisions which appear in Table 1, Figure 1 depicts the survival data of those children with acute lymphocytic leukemia plotting the percentage of patients surviving from the time of diagnosis against the survival time in months. As can be seen, there is a significant difference in the survival of those seen between 1960 and 1962 as compared with that in cases diagnosed since then. The earlier groups had a median survival of 4.6 and 6 months. For those reported to the Central Cancer Registry from 1963 to 1965 inclusive, the median

Table 1

1960 - 1962	*ALL*	*AML*
W. Va. Central Cancer Registry	12	7
West Virginia University Hospital	6	2
1963 - 1965		
W. Va. Central Cancer Registry	26	9
West Virginia University Hospital	14	5
Total	58	23

ALL—Acute Lymphocytic Leukemia
AML—Acute Myelocytic Leukemia

Children under 16 years of age with a diagnosis of acute leukemia between 1960 and 1965 seen at the West Virginia University Hospital and reported to the West Virginia Central Cancer Registry.

The Author

- **Barbara Jones, M. D., Associate Professor, Department of Pediatrics, West Virginia University School of Medicine, Morgantown.**

*This investigation was supported by Public Health Research Grant CA-07757.

Submitted to the Publication Committee, January 19, 1967.

survival was 10.6 months and for those seen at WVU Hospital, 17.3 months. In the latter group of 14 patients, four are still alive 24, 26, 30 and 35 months after diagnosis. Twenty-six patients from the Cancer Registry were treated at institutions other than WVU Hospital. Two of these were known to be alive 12 and 19 months after diagnosis, and follow-up information was unavailable in five additional cases. The survival curve was calculated assuming that these patients are still alive. The median survival of 10.6 months would be shorter if these five patients lived less than 10 months.

Possible Factors in Survival Discrepancy

The discrepancy in median survival between 10.6 months and 17.3 months in the 1963 to 1965 group may be ascribable to at least two factors. In the former group there were five deaths within two months of diagnosis which may reflect the seriousness of the initial symptoms, and perhaps some of these children were too ill to be referred to centers for definitive chemotherapy. Early deaths in acute leukemia generally are due to sepsis or uncontrollable hemorrhage. The 17.3-month median survival of those treated at WVU Hospital reflects the experience of the writer since becoming a participating member of Acute Leukemia Group B, a cooperative chemotherapy group which is investigating the most effective means of treating acute leukemia. Thus, an intensive approach to the chemotherapy of acute leukemia is advantageous, not detrimental, to the patient.

There has been no significant change in the survival of children with acute myelocytic leukemia and the median survival is three months throughout the six-year period.

Comment

The principal reasons for the improved survival in childhood acute lymphocytic leukemia are availability of more chemotherapeutic agents which are active against the disease, better understanding of their use, and vigorous application of adjuvant therapy including blood transfusions, platelet transfusions and antibiotics.

The most effective drug which has become available in recent years is Vincristine,[4,5] a vinca alkaloid which when used in combination with prednisone produces complete hematologic remissions in 84 per cent of cases of acute lymphocytic leukemia in children.[2] The other advantageous feature of this drug rests in the observation that two or three remissions may be produced before drug resistance occurs. Of even more importance than availability of a new drug is

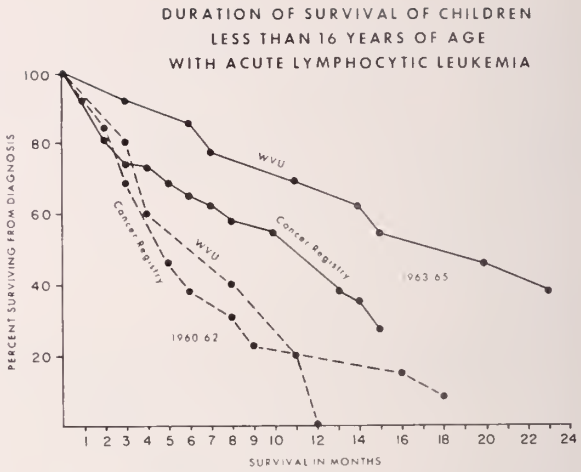

Figure 1. Duration of survival of children with acute lymphocytic leukemia 1960-1965.

better understanding of effective use of the drug armamentarium.

In recent years it has been recognized that treatment of acute leukemia can be divided into two stages, namely, *remission induction* and *remission maintenance.* A complete hematologic remission is achieved when the bone marrow contains less than five per cent blast cells, and the peripheral blood is normal in terms of hemoglobin value, white count and differential, and platelet count. In addition, all signs of hepatosplenomegaly and lymphadenopathy have subsided. With present-day therapy four to six weeks of intensive treatment generally are required to achieve a remission. Subsequent to this clinical and hematologic improvement, some form of drug therapy is continued in order to maintain the remission for the longest possible period of time.

Extensive clinical trials carried out under controlled conditions have adequately demonstrated that the percentage of complete hematologic remissions in children with acute lymphocytic leukemia is 80 to 85 per cent when the initial therapy consists of Prednisone combined either with Vincristine,[2] 6-Mercaptopurine,[6,7] or Methotrexate.[7] When any one of these four drugs is used alone, the remission rate varies between 21 per cent and 57 per cent.[4,5,8,9] Therefore, it can be concluded that combined therapy is far superior to that of single agents for *remission induction.*

The second therapeutic dictum is that some drugs are superior for the induction of remission such as those combinations mentioned above while only some of these are valuable in maintaining remissions once they have been achieved. To date, the most effective drugs for

remission maintenance are 6-Mercaptopurine[6] and Methotrexate.[2] It has been further adequately demonstrated that Methotrexate administered intramuscularly twice a week results in longer remissions than does the daily oral administration of the drug.[2] The average length of remission with the former regimen is 74 weeks as compared with 14 weeks with the latter. Remissions maintained with 6-Mercaptopurine average 33 weeks. Implied in this discussion is the conclusion that longer remissions are attained with maintenance therapy than without it and, in fact, when remissions are produced with the usual drugs and then all antileukemic medication discontinued during the remission, the average length of remission is only nine weeks.[8]

Since all known effective antileukemic therapy is predicated on the destruction of lymphoblasts in the bone marrow, severe bone marrow hypoplasia and the accompanying peripheral blood pancytopenia must be expected. Blood transfusions and platelet transfusions usually will tide the patient over until bone marrow regeneration occurs. The moderate to marked leukopenia predisposes to infection, hence, when signs of infection do occur, prompt adequate antibiotic therapy must be instituted. Children with leukemia not infrequently die of hemorrhage or overwhelming infection, and appropriate measures must be taken to prevent this occurrence.

Conclusions

Progress is being made in the treatment of acute lymphocytic leukemia in that the average survival time, after diagnosis, has been prolonged from the eight to ten months in 1960 to 17 months in 1966. In order to achieve this result and to extend the life span of these children even further, intensive chemotherapy and supportive care must be given along with continued search for more effective drugs and further investigation of the most effective way of administering the drugs available.

Acknowledgment

The assistance of the West Virginia Central Cancer Registry in collecting data, as well as its permission to publish the data, is gratefully acknowledged.

References

1. Sutow, W. W., et al: Studies of ACTH, Hydrocortisone and 6-Mercaptopurine in Treatment of Children with Acute Leukemia, J. Pediat. 61:693, 1962.
2. Selawry, O. S. et al: New Treatment Schedule With Improved Survival in Childhood Leukemia, JAMA 194:75, 1965.
3. Unpublished data—Acute Leukemia Group B.
4. Karon, M., et al: Role of Vincristine in Treatment of Childhood Acute Leukemia, Clin. Pharm. & Therap. 7:332, 1966.
5. Heyn, R. M., et al: Vincristine in Treatment of Acute Leukemia in Children, Pediatrics 38:82, 1966.
6. Frei, E., III, et al: Effectiveness of Combinations of Antileukemic Agents in Inducing and Maintaining Remission in Children With Acute Leukemia, Blood 26:642, 1965.
7. Krivit, W., et al: Induction of Remission in Acute Leukemia of Childhood by Combination of Prednisone and Either 6-Mercaptopurine or Methotrexate, J. Pediat. 68:965, 1966.
8. Freireich, E. J., et al: Effect of 6-Mercaptopurine on Duration of Steroid-Induced Remissions in Acute Leukemia: A Model for Evaluation of Other Potentially Useful Therapy, Blood 21:699, 1963.
9. Frei, E., III, et al: Studies of Sequential and Combination Antimetabolite Therapy in Acute Leukemia: 6-Mercaptopurine and Methotrexate, Blood 18:431, 1961.

Computer at the Bedside?

As to the evaluation of medicines for efficacy and safety, the computer is not the final and perfect answer, useful though it is. What the physician feels and perceives at the bedside of his patient may not fit into the square, or oblong or round hole of the punch card; but his observations are often a surer guide to the usefulness of a particular medicament for a particular patient. In the interest of the patient—that individual so unique that there is not another entirely like him in he whole wide world—we must be careful lest the scientific pendulum swing too far in the direction of mechanistic technology.—J. Mark Hiebert, M. D.

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La Roque Intra-Abdominal Approach for Removal Of Hernial Sac of Inguinal and Femoral Hernia

Bernard W. Wilkinson, M. D.

HERNIA probably was treated by primitive man for it undoubtedly is as old as the history of man. In the early treatment, the reducible hernia was bandaged. Operation was never attempted for strangulated hernia for its cause was never understood.

Hippocrates, who lived in the fourth century B.C. refers to the hernia. Celsus, who lived in the first century A.D., operated extensively for repair of umbilical hernia and less frequently for that of the inguinal variety. For the inoperable nonstrangulated hernia, he used the ancient *emplastrum contra-ruptura* and kept the patient in bed for 40 days. He described and practiced both ligation and excision of the hernial sac, with suture of the opening.

During the thirteenth and fourteenth centuries, the most notable hernia surgeons were Roger of Salerno (1210), Roland (1250), William of Salicet (1230), Theodoric in Bolonga, Lanfrane (1315) in Paris, and Guy de Chauliac of Montpellier.

Guy de Chauliac was considered the master surgeon of his time. He was a student of anatomy and was the first to distinguish umbilical from inguinal and femoral hernias. His great work was published in 1363.

The age of the Renaissance (fourteenth and sixteenth centuries), the period of transition between medieval and modern times, marked phenomenal progress in the arts and sciences. In the sixteenth century, decided progress was made in surgery owing to the gradual lifting of the ban on dissection. To this period belongs the "royal stitch" practiced by Fabricus and Aquapendente. These were methods of snaring the hernial sac with wire and separating it from the cord.

With the eighteenth century came awakening in the study of anatomy and improvement in surgery. A vast amount of literature has appeared concerning the operative treatment of hernia. In the eighteenth century, castration was performed so frequently during hernia operations that official edicts were issued in many countries forbidding removal of the testes.

Submitted to the Publication Committee, October 19, 1966.

The Author

- Bernard W. Wilkinson, M. D., 217 Washington Avenue, Clarksburg, West Virginia.

At the beginning of the nineteenth century, operation for nonstrangulated hernia by incision of the sac carried such a high mortality rate that the technique was abandoned by such eminent surgeons as Cooper, Scarpa, Boyer, and others.

During the nineteenth century, Cooper and Scarpa published their classic monographs, and one might say that this was the dawn of the modern era of surgery for the repair of hernia.

The modern treatment of inguinal hernia dates from the introduction of antiseptic surgery by Lister, in 1871, and the epoch-making papers published by Marcy, in 1881. Lister and Marcy were the first to advocate high ligation of the sac, transplantation of the cord, and reconstruction of the inguinal canal, as practiced today, but in the case of Lister, early communication is so lacking in detail that priority hardly can be awarded him though he was one of the pioneers in the use of absorbable suture. His works on the treatment of hernia changed the innumerable methods of treatment and from this time on, the work on hernia overshadowed the countless methods that had been used with more or less questionable results up to that time.

Henry O. Marcy, who was Professor of Surgery at Harvard, was known by his friends as "Hernia-O-Marcy." An interesting note of Marcy's report on hernia at a meeting in London was given by Watson.[1] He tells of a personal conversation he had with Marcy. He states that Marcy told him that while reading his paper, he saw Bassini in the audience. Bassini was listening intently and his expression of understanding seemed to change to one of pleasant conjecture. He did not discuss Marcy's paper. Marcy called the absorbable suture the feature of his technique, and he believed it responsible

for the exceptionally good results he was reporting, which had so interested Bassini.

Bassini had instantly grasped the secret of Marcy's success believing it to lie more in high ligation of the sac and restoration of the obliquity of the inguinal canal than in the absorbable suture. So, when he returned to Padu, he adopted Marcy's technique and, in 1889, reported the cases of many patients treated by the Bassini operation.

Be that as it may, on December 23, 1884, Edward Bassini, Professor of Surgery at the University of Padu, performed his first operation for the radical cure of inguinal hernia by the method which has come down to us as the Bassini operation. Four and one-half years later, his patient was found definitely cured.

The essential steps of the Bassini operation are recorded below. All surgeons know these steps, but I will review them here because following the operation that I will describe for entering the abdomen and removing the sac, one can repair the canal either by the Bassini or the Ferguson method. For that reason, I will describe these operations. The essential steps, therefore, of the Bassini operation are:

1. Free exposure of the inguinal canal from a little above the internal ring to the external ring.

2. Excision of the sac with high ligation of its neck.

3. Dislocation of the cord.

4. Accurate suture of the lower border of the internal oblique and transversalis muscles with their conjoined tendon to the under surface of Poupart's ligament.

5. Closure of the aponeurosis of the external oblique over the cord.

On June 13, 1899, Halsted,[2] of the newly opened Johns Hopkins Hospital, performed *his* first operation for radical cure of inguinal hernia.

On November 4, 1899, he presented this patient and four others at a meeting of the Johns Hopkins Medical Society and described his technique of operation.

Halsted Technique

Halsted's Technique consisted of making an incision through the tissue to the peritoneum from the external ring to a point beyond the internal ring, extirpating the sac fresh with the peritoneum, sewing the opening in the peritoneum, stitching all the muscles together with a single layer of silk sutures underneath the cord, closing the skin and superficial fascia

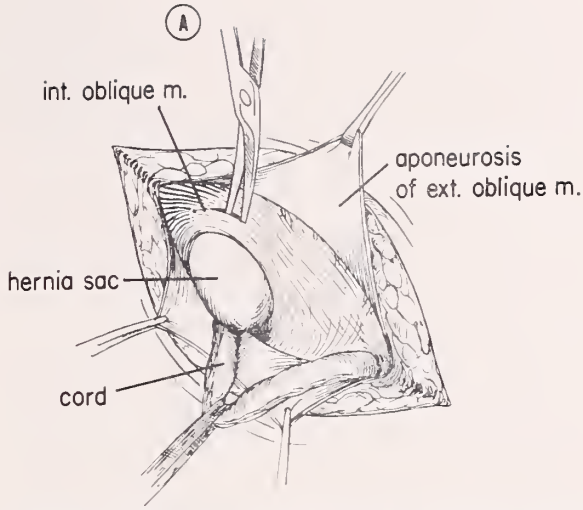

Figure A. Blunt forceps or scissors are inserted between muscle bundles of internal oblique and transversalis approximately 1 in. above lower margin of internal oblique, making good exposure of peritoneum well above neck of sac.

Early in his work, Halsted adopted the Bassini method of suturing the internal oblique and transversalis muscles and their conjoined tendon to the under surface of Poupart's ligament.

Halsted-Bassini Operation

With the clear understanding that subcutaneous transposition of the cord was Halsted's and firm closure of the muscles by suture of the internal oblique and transversalis with their conjoined tendon to the inner surface of Poupart's ligament was Bassini's, the method has been called the Halsted-Bassini operation.

Halsted, however, in 1903, announced that he had given up transposition of the cord, allowing it to remain undisturbed in its bed. He never again dislocated the cord.

AMA Hears Ferguson

Ferguson,[4] Professor of Surgery in the Chicago Postgraduate School of Medicine, on June 6, 1899, presented a paper before the meeting of the American Medical Association, describing a method for radical cure of oblique inguinal hernia, the essential steps of which he described as follows:

1. Free exposure of the contents of the inguinal canal by an incision from a point well above the internal ring to the conjoined tendon.

2. Excision of the sac with high ligation of the neck.

3. Suture of the internal oblique and transversalis muscles to the internal aspect of Poupart's ligament over the cord as it lies in its bed.

4. Closure of the aponeurosis of the external oblique muscle.

With the clear understanding that the design of allowing the cord to lie undisturbed in its bed is Ferguson's (with exception of Cooley's previous use of this method) and that suture of the internal oblique and transversalis muscles to the inguinal aspect of Poupart's ligament is Bassini's, the operation has been called the Ferguson method.

The La Roque Operation

It is my desire in this paper to call attention to the advantages of the La Roque operation for inguinal and femoral hernia by the abdominal approach. La Roque advocated the approach through a low, muscle-splitting incision above the internal ring in all cases of inguinal hernia. In 1924,[6] he elaborated on his technique and, in 1932,[7] described in detail his method for sliding hernia. Williams[8] and Barnes,[9] who had adopted the method from La Roque, emphasized it.

It was my great privilege to work with Doctor La Roque as a resident surgeon during the years that he was revising his writings on intra-abdominal methods of removal of inguinal and femoral hernia, with inclusion of many new illustrations, the latter now shown in all leading works on general surgery.

If I appear overenthusiastic regarding this subject, it is because I was deeply impressed with the operation; also, thanks to Doctor La Roque's great teaching ability, I gained thorough knowledge of the operative procedure and, having used this method of approach in all of my inguinal and femoral hernia cases for the past 35 years, I am thoroughly convinced of the operation's soundness.

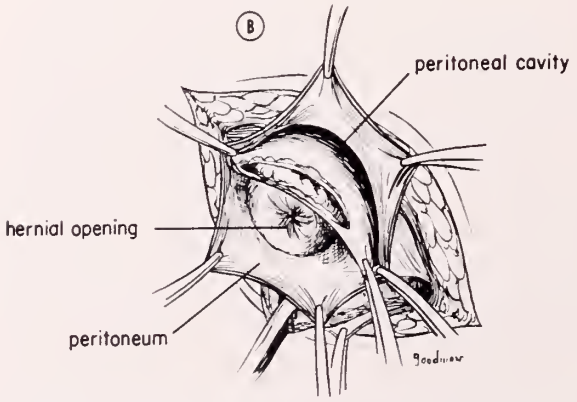

Figure B. Peritoneal cavity has been opened. Hernial opening is seen from within; traction is made on lower edge of peritoneal incision. Incision is being made above neck of sac, and sac is being excised and isolated from peritoneal cavity.

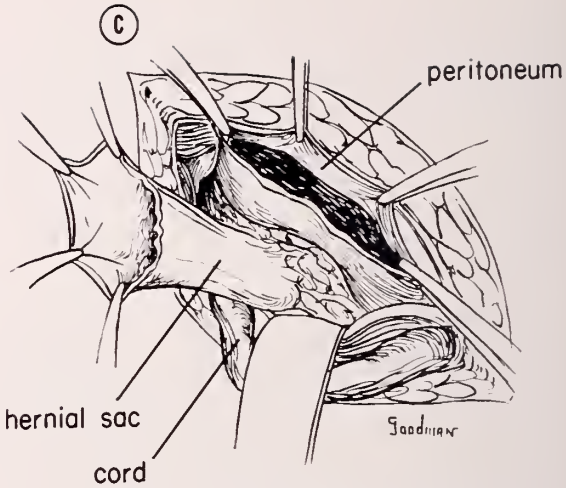

Figure C. Sac removal almost completed.

Secret of Cure

La Roque always emphasized the fact that the secret of cure for inguinal and femoral hernia lay in complete removal of the sac and reconstruction of the canal. Removal of the entire sac is of vital importance in prevention of recurrence. Sometimes the patient leaves the operating room with the actual beginning of a hernia, due to the small remnant of the sac remaining. La Roque asserted repeatedly that the only operation for hernia needed in the case of a child under the age of 12 was removal of the hernial sac; he further advocated not closing the canal in children under 12 years of age. He contended that too much manipulation around the canal which, in turn, would be around the cord structure and testicle, contributed to atrophy of the testicle. Also, he did not advocate operating on young children for hernia, inguinal or femoral, unless as an emergency procedure.

Difficulty in Locating and Identifying Sac

In discussing this operation, Doctor La Roque often commented on the difficulty sometimes experienced in locating and identifying the hernial sac, and cited a case in which the bladder was opened by accident. He stated further that he had difficulty with the Bassini approach in sliding hernia.

Specifics of Bassini and Halsted Operations

The Bassini and Halsted operative procedures for the cure of hernia have been directed largely, if not solely, to methods of closure of the canal and consist of dissecting up the hernial sac from below, removing the anatomical coverings of the sac by brushing them away until the neck of the sac is clearly exposed, and then ligating or suturing it. This operation is being done every

day by accomplished surgeons, with consistently good results; even so, in small hernias, when the sac is dissected from below through the inguinal canal, there is, of necessity, injury to the cremaster muscle and the sac may not be always easily found, and the line of cleavage between the peritoneum and sac and surrounding structures not always easily determined.

In cases of long-standing hernia, the line of cleavage may be difficult to find and during exploration to locate it, the inguinal canal is being greatly enlarged. Surrounding structures are being traumatized, important structures injured, and a lot of what Doctor La Roque called "digging in," "scrubbing out," and "pulling down" takes place.

Reference to Abdominal Approach in Literature

In the literature, the first reference to an abdominal approach that I was able to find was that of Robbins,[10] of Richmond, Virginia, who, in 1909, advocated a right rectus incision for release of the bowel in strangulated inguinal hernia.

Moschowitz,[11] in 1925, in reporting an operative technique for the cure of sliding hernia, described an approach through a small, low, McBurney incision. This, of course, was after La Roque's original description of his operation.

Doctor La Roque once remarked to me that he had told Moschowitz that his (Moschowitz's) operation for femoral hernia was the same as the one he himself had devised for inguinal hernia. It is surprising that the advantage of this method has not been more widely recognized. The apparent lack of interest constitutes my main reason for bringing the operation to the attention of surgeons once more.

Description of Operation

An oblique hernia incision is made 2 cm. above and parallel with Poupart's ligament for the length of the inguinal canal to a point just below the external ring. The aponeurosis of the external oblique is divided throughout the length of the canal. The lower portion of the internal oblique, the edge of the rectus, the contents of the inguinal canal and the shelving edge of Poupart's ligaments are exposed. By means of a blunt dissector scissors, the internal oblique and transversalis muscles are split in the line of their fibers approximately 1 inch above the lower margins (Figure A), and the peritoneum exposed and opened well above the internal ring as for an appendectomy. From the inner side of the abdomen, it is easy to distinguish the type of hernia, whether direct or indirect inguinal, whether femoral, or whether of an anomalous type; also, the vas deferens, vessels, cord, urinary bladder are easily and accrately identified. When it is necessary to release incarcerated bowel, omentum or other organs within the sac, the neck of the sac may be cut or stretched from within.

Peritoneal margins are grasped at the lower end of the wound on each side of the hernial neck inward as far as the bladder and outward as far as the internal ring. Using gentle traction, this part of the peritoneum is lifted away from its underlying areolar tissue. It is freed by blunt dissection.

An incision is then made along the inner border of the hernial opening (Figure B) through the peritoneum, and the sac is excised from the abdominal cavity with which it had been continuous. A finger is then inserted into the sac and the sac dissected free by blunt dissection (Figure C). Elements of the spermatic cord are not disturbed.

Peritoneum is then closed. Muscles are closed as in muscle-splitting McBurney, and one can return to the operation for closure of the canal by the plastic method of Bassini or Ferguson. The surgeon may use the closure of choice; whether he uses Cooper's or Poupart's ligament repair is up to him.

Advantages of the La Roque approach are as follows:

1. It can be used for any type of inguinal or femoral hernia.

2. The hernia defect can be viewed from above and below.

3. Its relation to other structures can be determined.

4. The ring-bearing portion of the peritoneum is excised completely along with redundant peritoneum, eliminating the dimple that sometimes is left when the approach from below is used.

5. Sliding hernia in which the protrusion, caused by the sigmoid or cecum being extraperitoneal, can never be satisfactorily handled by any other method since the problem is to develop a sling by plastic repair of the peritoneum so as to force the cecum or sigmoid to hang free intraperitonealy.

6. By using the La Roque method, there is no danger of missing one leg of the so-called pantaloon type of hernia.

7. After a portion of bowel that was strangulated has been released, it can be replaced in

the cavity and inspected at will before the peritoneum is closed.

8. If resection of a gangrenous portion of the bowel is necessary, good exposure of the mesentery is obtained, which otherwise would be difficult through the sac from below.

9. The sac is found with ease. There is absence of what Le Roque called "digging in," "scrubbing out" and "pulling down."

10. It can be used in inguinal hernia or femoral hernia when dealing surgically with primary pelvic disease in women.

References

1. Watson, L. E.: Hernia, St. Louis, C. V. Mosby Company, 1948, ed. 3.
2. Bull. Johns Hopkins Hosp. 1:12-13, c. 1890.
3. Ibid.: 14:208-214, c. 1903.
4. JAMA 33:6, c. 1899.
5. La Roque, G. P.: Surg., Gynec. & Obst. 29:307, c. 1919.
6. Ibid.: Ann. Surg. 79:375, c. 1924.
7. Ibid.: Arch. Surg. Vol. 24, 1932.
8. Williams, C.: Ann. Surg. 126:612, c. 1947.
9. Barnes, V. A.: M. Monthly 66:395, c. 1939.
10. Robbins, C.: Old Dominion J. Med. & Surg., Vol. 8, c. 1909.
11. Moschowitz, A. V.: Ann. Surg., Vol. 81, c. 1925.

Manuscript Information

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Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

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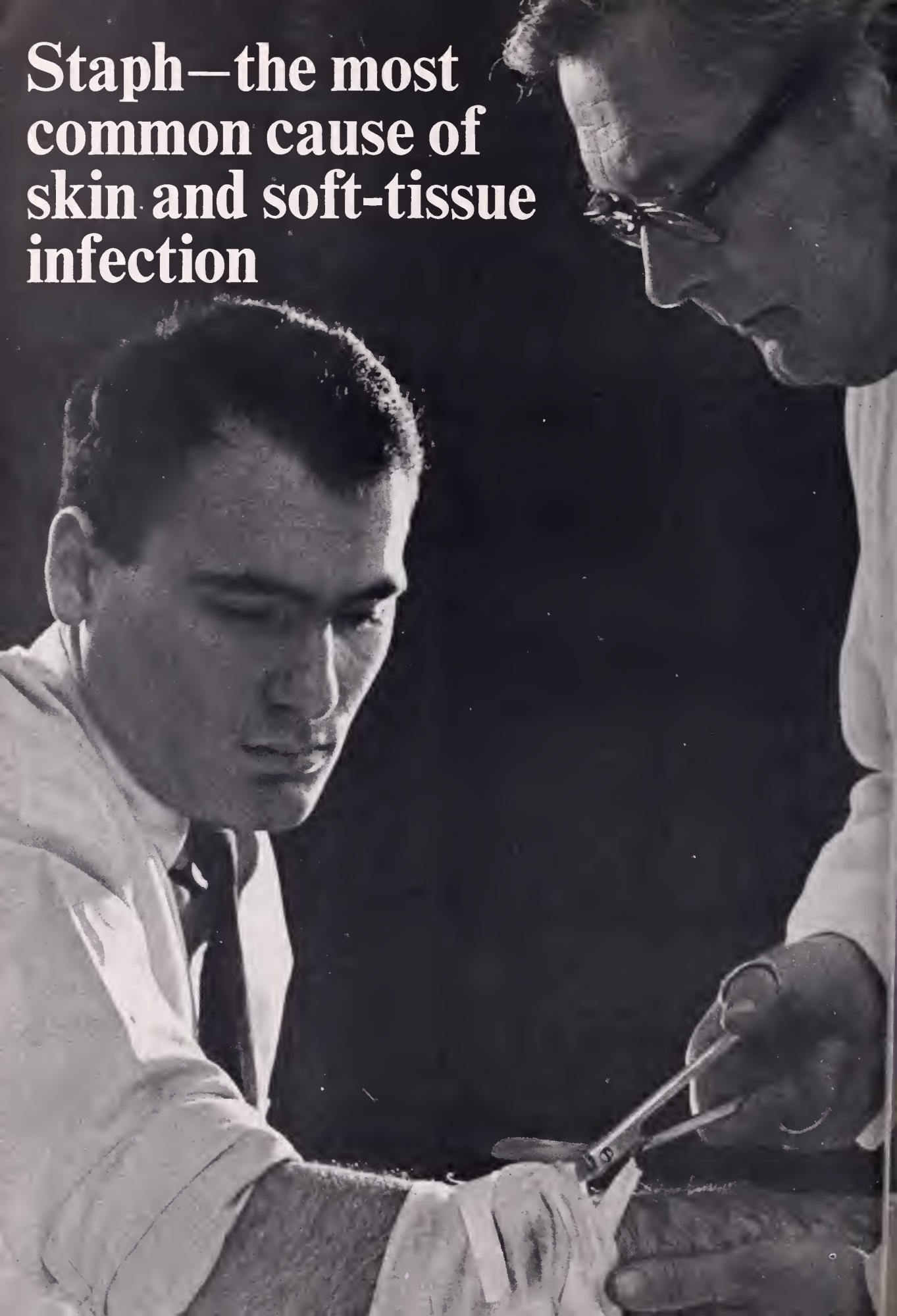
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References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965*, reported by Griffith, L.J., Staphylococcus Reference Laboratory, V. A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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Special Article

Federal Participation in the West Virginia State Tuberculosis Control Program*

Alfonso H. Holguin, M. D.

For a number of years in the past our nationwide progress against tuberculosis was so successful we were convinced that it was just a matter of years before the disease would no longer be a problem. While we knew that tuberculosis case-finding would become more difficult when there were fewer cases to be found, most of us assumed that we would simply have to work harder at what we were already doing —mostly x-raying as many people as possible— and the job would get done. But tuberculosis proved to be more stubborn than we thought it could be. The outcome of this stubborn resistance was the Surgeon General's Task Force. The program proposed by this group of authorities contained no miraculous discoveries nor unknown procedures. What it did, in fact, was bring together into one comprehensive plan a well-ordered program to renew our attack against the disease. They recognized that the major mistake of the past was in our faltering attempt to apply what knowledge was already available and to apply it intelligently.

The Task Force pointed out that rational orientation of tuberculosis control activities is toward those persons in the population who most need services. Because tuberculosis is communicable, these services are in the interest of the community as well as the recipients. Complete treatment of each person who has tuberculosis not only insures the individual's recovery, but also protects others from his disease. Every case that is found early, before it has become communicable, prevents the spread of infection. But even more effectively, infection is prevented when persons at special risk are identified and given service to preclude the development of communicable tuberculosis.

Because tuberculosis control services, however they benefit individuals, are public health measures for the protection of the community, common sense dictates that everyone who needs them should be eligible to receive them at no cost. Many persons who need attention in the interest of tuberculosis control do not have physical discomfort that would motivate them to seek or accept services, especially over the needed long periods of time. The most skillful persuasion will be futile if the services are restricted. And I would like to add that the very best services will be futile if the persuasion is not the most skillful.

The Author

- **Alfonso H. Holguin, M. D., Chief, Tuberculosis Program, Public Health Service, Department of Health, Education and Welfare, National Communicable Disease Center, Atlanta, Georgia.**

I have been asked to discuss case-finding, an important activity of any tuberculosis control program. However, I would like to discuss more fully the essential companion activity, case-holding. The case-finding method given highest priority by the Task Force is contact follow-up. This technique has been the most productive in finding cases (from project reports it has been noted that on the average, 35 new cases were found for each 1,000 contacts examined). Hospital admission x-ray programs have found between 2.5 to 4.5 new cases/1,000 x-rays and x-raying of selected populations have found .4/1,000 x-rays.

"Multi-Problem" People

Tuberculosis patients are multi-problem people. Tuberculosis is, in most instances, only one of a number of critical problems. At a recent conference on tuberculosis follow-up and supervision in Chicago, the statement was made that we had better get rid of some of our worn-out concepts about patients and at the same time

*Presented before the Annual Meeting of the West Virginia Tuberculosis and Health Association in Charleston, September 7, 1966.

Submitted to the Publication Committee, October 4, 1966.

outlaw such meaningless expressions as *recalcitrant, skid-row,* and *marginal.* I am exasperated at the constant attempt to blame the patients for the difficulties of treatment.

Our tuberculosis patient population is gradually changing. More and more of our patients are coming from parts of the population that are difficult to reach. We see barriers of *age, disability, income, education,* and, more importantly, *communication* developing. I do not mean barriers of language. Language is seldom a barrier where there is courtesy and mutual respect. Our attitudes arising from backgrounds which are different from our patients' interfere with the necessary communication and understanding we must have to help them. Our services to the patient are too often limited by habit or convenience and supported by legal trivialities. The result is we drive away the very persons who most need our services. I believe we have the responsibility, or better yet, the moral obligation to change our habits and attitudes rather than force a set of unworkable rules on patients who are more concerned with getting food and shelter than they are with the vague discomforts of a complicated disease.

The Task Force emphasized that the persons known to have active disease have first priority in control services. Patients with active disease who are not in the hospital head this list and this is the first program priority of the West Virginia project. In 1965, of the 3,209 active tuberculosis cases on the register in West Virginia, 2,649 were at home. In providing services for patients outside of the hospital, two things are important—first, the care must be of high quality and to be of high quality, this must include regular medical examination and drugs. And, second, the patients must be persuaded and enabled to accept such care. I know that only too often this out-of-hospital treatment is plagued with ugly clinics, inconvenient hours, and untrained and indifferent staffs. And many of them are neither oriented nor staffed to do the job.

Task Force Program in West Virginia

The Task Force program in West Virginia now encompasses 40 of the 55 counties. The plan this year is to extend activities to eight of the 15 counties not now included. The purpose of the project is, as I have noted, to provide tuberculosis control services for those persons in West Virginia who most need services. These include non-hospitalized patients with active disease and persons with inactive disease for a five-year period after disease becomes inactive. The other groups selected by the Task Force and who are included are contacts of newly reported cases, and persons at high risk of developing disease, particularly those who might infect children.

Persons with recently inactive disease and contacts were selected because relapse is greatest during the first five years after disease becomes inactive and because contacts of new active cases are not only at exceedingly high risk of having active disease (19 per 1,000), but of developing disease during the first year after diagnosis of the index case (8.5 per 1,000). This risk is greatly reduced by the prophylactic administration of isoniazid. Not only should all contacts be examined at least twice a year, but they should receive drug treatment for a year if feasible.

The other point of emphasis concerns identification of persons at risk of developing tuberculosis and the provision of long-term services for them to prevent unrecognized disease from spreading. The plan involves finding sources of infection among persons most likely to infect children so that tuberculosis will not continually be transmitted to the next generation. The proposal is to tuberculin test children when they first enter school. Since these children have led somewhat sheltered lives it should not be difficult to find out who infected them and to prevent other members of the same family, especially children, from becoming infected. The importance of protecting children was also the reason for the Task Force recommendation that all school teachers and other persons who work regularly with children have periodic examinations. Since West Virginia still has a large tuberculosis problem, the objective of the special tuberculosis project grant is to continue to sustain the necessary efforts for maintaining basic tuberculosis services, to include additional activities when feasible, and to expand into new areas where there is a need.

Under this program the project grants will (1) Continue to provide the necessary diagnostic, treatment, and follow-up services through an organized tuberculosis clinic program for patients, contacts, and suspects; (2) Bring under treatment the known active tuberculosis patients and determine the activity status of those classified as "undetermined;" (3) Bring to examination and diagnosis the contacts of newly reported cases and the tuberculosis suspects; (4) Extend the project (including the services above) to additional counties in need of these services; (5) Augment medical and public health nursing services to the patients, contacts, and suspects in the project area; (6)

Provide necessary antituberculosis drugs to patients and prophylactic isoniazid to selected individuals as medically advised; (7) Increase laboratory services to clinic patients to include reagents, culture media, etc. for sputum examination due to the increased clinics in the project counties; and (8) Progressively assist other counties in the State with their tuberculosis problems as the need dictates.

In West Virginia, as in all of our other project areas, most of the special project funds are used to employ physicians, nurses, technicians, and other personnel required to provide the necessary services. In addition, many of the services are supported on a part-time or fee-for-service basis. For example, in West Virginia 24 full-time positions are being supported by project funds. In addition there are many part-time physicians, and many x-ray technicians and physicians are paid on a fee-for-service basis. The remaining funds are used to furnish drugs, medical supplies, x-rays, and the other clinic services that are needed.

As the project expands into other counties, additional personnel will be needed to provide services for the added patients. The intent of this program is to progressively provide the entire state with these services.

Other Aspects of the Program

At the same time careful consideration is being given to implementing other aspects of the Task Force Program. These include the identification of persons at risk of developing tuberculosis and the provision of long-term services for these individuals to prevent unrecognized disease from spreading. When feasible, an effort will be made to tuberculin test all children at first entrance to school. Those who react will be given a chest x-ray and their families and other persons with whom they have been closely associated will be tuberculin tested and positive reactors will receive chest x-rays. If they are pre-school children, the positive reactors will be given a course of prophylactic isoniazid. Adult reactors will receive whatever diagnostic service they need, and those who fall into high-risk groups because of their x-ray findings, age, weight, or health problems, will receive a course of prophylactic isoniazid and/or periodic examinations as long as they are associated with children.

Insofar as possible with funds available, a program will be designed to encourage all school teachers and other school employees to be tuberculin tested, and nonreactors scheduled for annual tuberculin tests. Reactors will be x-rayed and scheduled for periodic examination according to their risk status.

In addition to skin testing first-graders, a program will be developed to tuberculin test all 14-year-old children in the schools in order to reach this high-risk group. Reactors will be followed up with x-rays and periodic examinations, and provided with prophylactic drugs if indicated.

Social and Human Problems

All of these activities are essential if we are to make any inroads against tuberculosis. However, while not wishing to minimize the importance of the technical and medical aspects of tuberculosis control, the social and human problems are gradually assuming more important roles. Money will help, but the most important question is, "How can we persuade patients to accept our medical help?" While we are technically and medically capable of advancing toward the final defeat of the tubercle bacillus, we are not always capable in human terms. Our attitudes conflict with patient attitudes. Seeing that patients take their medication with spot urine tests may be helpful, but if you find out that a particular patient is not taking his drugs, that he does not come back for his clinic visit, what does this tell you besides the obvious? It *should* tell you that the patient has not been adequately motivated to continue treatment.

It is impossible for me to review all of the opinions and attitudes that we as professionals bring to our patients. I can, however, review several critical areas where those of us who work with patients are likely to encounter artificial barriers—barriers to the acceptance of treatment and assistance by people who need them most.

First, we cannot succeed unless the patient assumes some responsibility for his treatment. The prolonged therapy for tuberculosis demands this. To achieve this, we must first examine those critical areas of patient-staff relationships. With due regard for staff welfare, greater consideration should be given to the requirements and convenience of the patient.

I firmly believe that the physician must see each patient or potential patient when he first arrives for treatment and at regular intervals thereafter. During regular clinic hours, the physician should be available for all patients who want to see him.

A definite effort should be made to assure a long-term personal relationship between patient and physician, and between patient and nurse, and the staff should demonstrate a personal concern for the health and welfare of the patient.

Location of Clinics

The clinics should operate at hours that would permit maximum use of services with a minimum of inconvenience for the patient. Undue delay and waiting must be avoided. Clinics should also be conveniently located for patient needs rather than for staff needs. Careful consideration should be given to ethnic patterns, mobility of patients, and other neighborhood characteristics when locating clinics.

Patients with disabilities coexisting with tuberculosis should be cared for or referred to the appropriate physician, with lines of communication kept open to the patient.

In most instances, there are few barriers to patient acceptance of clinic programs and only a small part of patient populations will fail to cooperate. Usually a minor variation in the clinic activities will make the program attractive to most of this group. For the small percentage of people who still find the clinic program unacceptable, we may need to prepare a special program to meet their needs and problems.

We have seen that where clinics are designed specifically to meet ethnic, social, educational, and behavorial patterns of various groups who live in high-incidence areas, there has been a remarkable reduction in missed clinic visits from 25 per cent to 6 per cent.

Finally, there should also be a joint community-health department relationship that includes the private physician. I know the private physician is very often the first person to see a patient but he is all too often the last person to be thought of in health department planning and programming.

These are the objective areas that can be carefully examined to obtain patient acceptance of treatment.

The subjective areas are those which involve our own attitudes toward the patient. To these we bring all of our cultural differences, beliefs, prejudices, and experiences. There are no ready answers to patient understanding. It is easy to observe that people are different. But difference is a two-way word. It is much harder, and takes considerable imagination and a bit of detachment, to realize that we may be "different" to a patient . . . a difference we must overcome if we are to succeed in communicating to the patient that we care about his health and welfare.

Most patients will cooperate if we give them any kind of a chance. To do this, we must fit our programs to the needs, convenience, and wishes of the patients. Then rather than convincing ourselves that what we are doing is in the best interest of the patient, convince the patient that it is in *his* best interest to accept our medical services.

How To Impede Research

During an earlier age of drug development in the U. S., the evaluation of compounds depended largely on trial-and-error methods in the hands of the general practitioners. The increasing complexity of drugs, as well as the growing sophistication of science in general, stimulated a trend toward more systematized evaluation of techniques. The danger, however, is that the pendulum may swing too far in this direction under the stimulus of public demand for perfect drugs and the government's increasing involvement in the evaluation process. This could impede the very research that produces golden ages in discovery.—Morris Fishbein, M. D., in *Medical World News.*

THIS SPACE CONTRIBUTED BY THE PUBLISHER

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A message from . . .

The President

HAPPY MOTHER'S DAY

HAPPY Mother's Day to all you females, Mothers and Potentials!!

Went to the Southeastern Surgical Conference in Miami—and of all the meetings I've attended as President and before *nobody* puts on a meeting like *our* Bill and Ed!!

The sun shone nicely in Florida. College kids—sure they had fun but being exposed to some very closely (two nieces and a nephew) I'm sure they are not the "crud" that a Florida official called them publicly. How a State official can speak so positively, I can't see. He will hear further from me!! Of the 235 plus kids arrested, less than one-third were college kids—the over two-thirds then were the State Attorney General's Floridians!!!

Attended the AMA meeting on Emergency Care. Seems strange no such meeting had been held before. Much good must come out of this meeting and I'm sure we will have to go over our own State and jack up emergency care and become more active in disaster planning. The Governor has the say-so about the new highway bill and our State Health Department has already been having courses to train ambulance attendants. We, as doctors, and as the State Medical Association and each of its county components *must* become more actively involved in this Emergency Care. Of course, local citizens have to be aroused and made a part of this emergency care. When we think of emergency care, trauma comes to mind: *all medical* aspects must be thought of and appropriate plans made. Let's do something positive, not another Medicare! And you all can see what happened to the auto industry!

An active "End Measles" campaign should be put on by each county and each city and hamlet where available. A day similar to our oral polio days would do the trick. Any town, city or county interested in such a campaign and needing further help contact the State Office—we can furnish advice but not the vaccine!! Incidently, in West Virginia, where the population is 1,860,421, there are 93,021 susceptible to measles between the ages of one and twelve. Of these, 37,000 are expected to get measles and 152 will have complications, 37 with encephalitis and 12 will become mentally retarded; Oh yes, four will die!!! Now the cost of the care—hospital, drug and doctor bills—plus the cost for caring for the mentally retarded ($1,200,000) will be 1.7 million dollars—the vaccine cost would be $140,000. *Think*—I don't believe we can afford *not* to have an "End Measles" campaign!

The Centennial celebration in Fairmont was 10 April 67—saw many of you there. A full report will be in the newspapers and elsewhere in this issue of *The Journal.* The Woman's Auxiliary will be given the use of this page next month—so, I'll be back in July and—Happy Mother's Day, Mom.

RICHARD E. FLOOD, M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIAL

PROGRESS IN THE TREATMENT OF CHILDHOOD LEUKEMIA

Careful appraisal of the paper by Barbara Jones, M. D., "Progress in the Treatment of Childhood Leukemia," in this issue of *The Journal* is suggested for all physicians. There are a number of points of emphasis, both implied and obvious.

Research in the etiology and treatment of leukemia in children has, in the past few years, made tremendous advances that have evolved primarily through the concept of combined cooperative research by groups of physicians of a number of universities and medical centers working together. In this way, a specific therapeutic regime can be evaluated more rapidly and completely as to its value than any single physician or department could ever hope to do; if for no other reason than the number of patients available to anyone. And yet, for the family of a leukemic child, or the family physician concerned, such a child no longer becomes a statistic, but a real important patient for whom we all want to do our very best. The "very best" can be best arrived at through such cooperative group research. And certainly, no longer is it warranted to feel as a physician that just because no cure is available our therapy should be limited. The many added months or years of fruitful, happy life which has resulted for the leukemic child because of the research efforts of physicians such as Doctor Jones and the members of the treatment group to which she belongs is ample proof and reward.

The concept of certain drugs being advantageous for remission induction and others for remission maintainence is new and very valuable. Other new drugs are also being investigated in similar ways. This revolutionary concept has brought us much closer to understanding basic leukemic cellular biochemistry and function and certainly closer to a realization that leukemia can, someday, be cured. Through the basic research of the cooperative groups at both the animal and human level this goal is within reach. We all wish them well.

Emphasis on the importance of highly specialized supportive care of the leukemic child by means of concentrated platelet transfusions to prevent or treat the complication of hemorrhage,

and the recognition and treatment of superimposed infection deserves mention also. Through these means of support some children, who might otherwise die early or later in the course of the disease, may be allowed to live to the point that chemotherapy can again induce a remission—again providing more months or years of a good life. Such therapy may only be available in university centers, but it is well worth it from the standpoint of the patient and his family, as well as the physician.

Finally, the family physician should feel rewarded that he has referred his leukemic patient to the University and Doctor Jones when such a patient is demonstrated to have a much better prolongation of life than occurs through individual treatment or as compared to others. He, at that point, has entered into a cooperative research effort which promises to find the best therapy available, or even a cure. Such cooperation is for the benefit of the family physician, the patient, and certainly helps support the research efforts of our own West Virginia University School of Medicine.—*Guest Editorial by William G. Klingberg, M. D.*

MORE ON APPALACHIA

Another interesting step in creative federalism was accomplished in our Nation's Capital on March 10, 1967. The occasion was a conference called by our State Medical Association, and attended by representatives of nine of the 12 Appalachian state medical societies. Also present were several representatives of the American Medical Association and the Appalachian Regional Commission.

Early in the day-long session it became apparent that a gamut of opinion on Appalachian health problems and their relief, ranged from simple lack of knowledge through a stage of confusion to an occasional peak of optimism as regards the future welfare of this infant titled by its progenitors as "Regional Demonstration Comprehensive Health Center." At least the baby is starting life in our poverty-stricken areas with a complete admixture of federal, state, areal and local genes attached to its chromosomial structure.

A description of two proposed regional projects in Ohio and West Virginia left no doubt as to the hopes and aspirations of their local proponents, and less doubt as to the sizable dent in federal funds authorized but not yet entirely appropriated.

There were many interesting sidelights to the meeting, mention of which is prohibited by lack of space and the desire to continue in a state of amity with professional and lay colleagues. The conference was worthwhile in the sense that nine Appalachian state medical societies will now have a mutual basis available for understanding the problems, and more important, the opportunity of adopting mutual standards for state medical approval of future demonstration health facility projects.

RETIREMENT INCOME

In recent weeks there has occurred a resurgence of interest in a particular manner of providing adequate and certain retirement income for physicians. It dates back to 1953 when a group of physicians in the State of Washington authorized Blue Shield to withhold 10 per cent of the amounts due them for services rendered with investment of these monies in an investment plan concerned with real estate, stocks and bonds. Upon retirement the individual physician receives a monthly income commensurate with the amount invested. Since these investments come from Blue Shield funds they are in reality "before tax dollars" and not subject to federal income tax. The number of years a participating physician would receive retirement income is the choice of the physician and might vary from a period of 10 years to life.

Recently, the local Blue Shield Plans have shown an interest in establishing such a retirement fund with an opening letter addressed to participating physicians by a member of our State Medical Association's Insurance Committee, who also functions as an official of the National Blue Shield Plans. It might be advisable and advantageous for our members to give serious consideration to this project, both on the state and local Blue Shield level. Any physician now on the retired list can testify as to the benefits of well-planned and adequate retirement income.

Who Controls 'Quality Control'?

Much is made of quality control of brand-named drugs. The question is, who will control the quality if only the generic name is used? The government? Not likely, in view of the many problems it already cannot solve. If the government had to exert quality control over all generically labeled drugs, this would be a fabulously expensive and time-consuming operation. Certainly neither the physician nor the consumer can do it. For some drugs, control is not very necessary, but there are too many for which it is essential and there is no easy way to separate the two groups. —Irvine H. Page, M. D., in *Modern Medicine.*

GENERAL NEWS

Dr. Perry E. Gresham Banquet Speaker At 100th Annual Meeting

Dr. Perry E. Gresham, President of Bethany College, has accepted an invitation to deliver the principal address at the Centennial Banquet which will be held during the 100th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 24-26.

Announcement of Doctor Gresham's acceptance was made jointly by Dr. James P. McMullen of Wellsburg, Chairman of the "Committee for 100," and Dr. Ray S. Greco of Weirton, Chairman of the Program Committee.

The Centennial Banquet will be held on Friday night, August 25, and will be preceded by a reception. Further details concerning the banquet and reception will be published in future issues of *The Journal.*

Doctor Gresham, who has served as President of Bethany College since 1953, received A.B. and B.D. degrees from Texas Christian University and completed requirements for the Ph.D. degree at the University of Chicago and Columbia University. He holds honorary degrees conferred on him by Texas Christian, Culver-Stockton College, University of Cincinnati, Youngstown University, Transylvania College and Chapman College.

He formerly served as Professor of Philosophy at Texas Christian University and is a past president of the Highland Broadcasting Company in Radford, Virginia. He has presented lectures at universities throughout this country, Canada, Mexico and the United Kingdom.

He is a past chairman of the Commission on Colleges and Universities, North Central Association, and a past president of the International Convention of Christian Churches (Disciples of Christ).

In 1963 he was one of five recipients of plaques from the Freedoms Foundation Leadership for Public Service in Education.

He is the author of four books.

Climax of Centennial Observance

The Annual Meeting at The Greenbrier will bring to a climax the observance of the 100th Anniversary of the founding of the West Virginia State Medical Association.

A dinner meeting was held in Wheeling on February 28 to commemorate a meeting held exactly 100 years to the day earlier for the purpose of preparing a call for the first meeting which was held in Fairmont on April 10, 1867. On April 10, 1967, the Marion County Medical Society sponsored a dinner meeting to commemorate the founding of the West Virginia State Medical Association in that city 100 years ago. (A report of the Fairmont meeting appears elsewhere in this issue of *The Journal*).

Dr. Perry E. Gresham, President, Bethany College

Other Speakers on Program

The Program Committee announced previously that Dr. Milford O. Rouse of Dallas had accepted an invitation to speak at the first session of the House of Delegates on Wednesday afternoon, August 23. Doctor Rouse is currently President Elect of the American Medical Association and will be installed as President at the Annual Convention in June.

Other physicians who have accepted invitations to appear as guest speaker include Dr. Charles A. Doan, Dean Emeritus of the Ohio State University College of Medicine, and Dr. Brian Blades, Washington, D. C., who is Lewis Saltz Professor of Surgery and Chairman, Department of Surgery, The George Washington University School of Medicine.

The Program Committee announced that acceptances also have been received from several other prominent physicians and surgeons and their names will be published in future issues of *The Journal.*

FOUNDERS DAY DINNER

April 10, 1967

More than 250 persons attended the "Founders Day Dinner" held at the Fairmont Hotel in Fairmont on April 10 to commemorate the founding of the West Virginia State Medical Association 100 years ago.

A large number of physicians and their wives from throughout the State traveled to Fairmont for the observance. Dr. Richard E. Flood of Weirton, President of the State Medical Association, and Mrs. Hu C. Myers of Philippi, President of the Woman's Auxiliary, were present as were a number of past presidents and current officers of the Association.

The principal speaker was Dr. William H. Stewart, Surgeon General of the U. S. Public Health Service. The subject of his address was "Partnership in Action." The address will be published in the June issue of *The Journal.*

Doctor Stewart was introduced by Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine.

The invocation and benediction were given by the Rev. Frank C. Marvin and the address of welcome was delivered by Dr. David Bressler, President of the Marion County Medical Society.

Dr. G. Thomas Evans, Secretary of the Society, was in charge of arrangements for the dinner meeting and he also served as master of ceremonies. Throughout the evening he cited a number of the outstanding accomplishments of the Association during the past 100 years.

Dr. James Z. Appel of Lancaster, Pennsylvania, Immediate Past President of the American Medical Association, presented a commemorative scroll to the State Medical Association on the occasion of its 100th Anniversary. Doctor Flood accepted the scroll on behalf of the members of the Association.

Also in attendance was Mr. Paul Crabtree, Executive Assistant to Gov. Hulett C. Smith, who brought official greetings from the Governor and the State of West Virginia.

Doctor Evans introduced two of the oldest living members of the Marion County Medical Society, Drs. H. L. Criss of Fairmont and J. J. Jenkins of Farmington.

The dinner was preceded by a reception and musical entertainment was provided by Jimmy Morgan.

Dr. Clark K. Sleeth (center in left picture), Dean of the WVU School of Medicine, is shown with two of the guests of honor at the Founders Day Dinner in Fairmont on April 10. At left is Dr. William H. Stewart, Surgeon General of the U. S. Public Health Service, who delivered the principal address. At right is Mr. Paul Crabtree, Executive Assistant to Gov. Hulett C. Smith, who was unable to attend because of a previous commitment. In right photo are: Dr. James Z. Appel of Lancaster, Pennsylvania, Immediate Past President of the American Medical Association; Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association; and Dr. G. Thomas Evans of Fairmont, Secretary of the Marion County Medical Society, which sponsored the dinner.

★

Left photo shows some of the persons who attended the Founders Day Dinner. From left to right are: Dr. B. B. Richmond of Beckley (face partially obscured); Mrs. Richmond; Dr. George F. Evans of Clarksburg, Editor of The Journal; Dr. Andrew J. Weaver of Clarksburg; Dr. E. Lyle Gage of Bluefield, Associate Editor of The Journal; and Dr. J. C. Huffman of Buckhannon. Doctor Weaver is a member of the Council of the Association. Doctors Evans, Gage and Huffman are Past Presidents of the Association. Picture at right shows three physicians admiring a scroll presented to the Association by the AMA in recognition of its 100th anniversary. From left to right are: Dr. G. Thomas Evans; Dr. Richard E. Flood; and Dr. Ray S. Greco of Weirton, Chairman of the Program Committee for the 100th Annual Meeting at The Greenbrier next August.

Public Health Association Meeting In Charleston, May 10-12

The complete program has been announced for the 43rd Annual State Health Conference, which will be conducted by the West Virginia Public Health Association in Charleston, May 10-12.

The Conference will get under way on Wednesday afternoon, May 10, with a business meeting of the West Virginia Association of Sanitarians. There will be an Executive Council dinner meeting and sanitarians' annual party that evening.

Mr. Guido Iannarelli, President of the Association, will preside at the first general session on Thursday morning, May 11. There will be a viral disease seminar, emphasizing rubella, with State Health Director N. H. Dyer serving as Moderator.

After lunch, there will be a brief annual membership business meeting. Also on Thursday afternoon, various sections of the Association will have their meetings. These include the Health Administration Section; the Clerical and Vital Statistic Section; Sanitarian, Laboratory and Industrial Hygiene Sections; the Nursing Section; the Health Education and Medical Services Section; and the Mental Health Section.

The President's Reception, Annual Banquet and Annual Dance will be held Thursday night.

Dr. M. A. Viggiano, President Elect of the Association, will preside Friday morning, May 12. Speakers that morning will include Dr. Daniel Hale of Princeton, Chairman of the Southern West Virginia Regional Health Council, and Bertlyn Bosley, Ph.D., of Washington, D. C., Nutrition Adviser to the Pan American Health Organization. Doctor Hale will speak on "The Appalachian Regional Health Program" and Doctor Bosley's topic will be "Nutrition in Latin American Health Programs."

Additional section meetings will be held in the afternoon.

Four persons will receive 25-year service awards. They are: Mrs. Cecilia McElwee, registered nurse for the Taylor County Health Department; Mr. Charles O. Snider, Sanitarian for the Harrison-Clarksburg Health Department; Dr. M. A. Viggiano, Health Officer of the Wetzel and Tyler County Health Departments; and Miss Mammie Watson, Clerk at the State Hygienic Laboratory.

The Public Health Association's Nominating Committee met in December and recommended the following slate of officers for 1967-68:

President Elect—Mrs. Bernice L. Vance, R.N., Harrison-Clarksburg Health Department, Clarksburg.

Vice President—Mr. William A. Nichols of Charleston, Executive Director of the West Virginia Division, American Cancer Society, Inc.

Treasurer—Mrs. Elaine W. Stanley of Charleston, Clerk, Fiscal Office, State Health Department.

Member-at-Large—Miss Juliann Ritter of Charleston, Executive Secretary, West Virginia Nurses Association.

Nominations may be made from the floor.

Doctor Viggiano, now President Elect, will become President when the new officers are installed.

House of Delegates to Meet Twice at The Greenbrier

The Program Committee has announced that there will be two sessions of the House of Delegates during the 100th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 24-26.

The first session of the House of Delegates will be held on Wednesday afternoon, August 23, the day preceding the formal opening of the Convention, and the final session will be held on Saturday afternoon, August 26.

The pre-convention meeting of the Council will be held on Wednesday morning and members of the Council have been urged to notify The Greenbrier immediately if they plan to register on Tuesday evening.

Delegates also are asked to arrange their schedules accordingly in order to be in attendance at the first session of the House of Delegates on Wednesday afternoon.

Action Due in August on Proposed Constitutional Amendments

Several amendments to the Constitution of the West Virginia State Medical Association, offered at the 99th Annual Meeting in White Sulphur Springs, August 25-27, 1966, will be acted upon finally by the House of Delegates at the 100th Annual Meeting at The Greenbrier, August 24-26, 1967.

The proposed amendments follow:

Article IX

Amend Article IX, Section 1, line 3, by deleting the word, "twelve," and substituting therefor the word, "fourteen."

Amend Article IX, Section 2, line 4, by deleting the words, "each year," and substituting therefor the words, "every second year as shall be provided for in the By-Laws for reapportionment of Councilor Districts."

Amend Article IX, Section 2, paragraph 3, line 4, by adding, "except as provided in the By-Laws pertinent to reapportionment of Councilor Districts."

Kanawha Medical Occupies Larger Office

The Executive Office of the Kanawha Medical Society became a close neighbor of the West Virginia State Medical Association during April.

The Society's staff moved from the seventh floor of the Atlas Building in Charleston to a larger office on the fourth floor, just two or three doors away from the West Virginia State Medical Association.

A part-time Executive Secretary, Mr. Don Crislip, and a full-time office secretary, Miss Jo Anderson, comprise the Kanawha Medical staff.

Rocky Mountain Cancer Meeting Program Announced

The program has been announced for the 21st Annual Rocky Mountain Cancer Conference, which will be held at the Brown Palace-West Hotel in Denver, Colorado, July 14-15.

Morning symposia will concern "What's New in Cancer" and "Cancer of the Biliary System and Its Related Structures."

Among participants in the Conference will be Dr. Milford O. Rouse of Dallas, Texas, President Elect of the American Medical Association, and Dr. Ashbel C. Williams, President of the American Cancer Society.

Other speakers will include:

Dr. Arthur J. Hunnicutt, an Oakland, California, surgeon; Dr. William T. Moss of Chicago Wesley Memorial Hospital; Dr. Richard J. Reitemeier, Chairman of a Section on Internal Medicine at the Mayo Clinic; Dr. William O. Russell of Houston, Texas; and Wendell M. Stanley, Ph. D., a Nobel Prize-winning virologist at the University of California at Berkeley.

Additional information about the meeting may be obtained by writing to: Rocky Mountain Cancer Conference, 1809 East 18th Avenue, Denver, Colorado 8.218.

3rd Quarter BS Benefits Top $1 Billion

For the second consecutive year, Blue Shield third quarter benefit payments topped the $1 billion mark, the National Association of Blue Shield Plans announced last month.

A record sum of $1,074,980,348 in benefits was paid on behalf of Blue Shield subscribers during the first nine months of 1966.

This is an increase of $57,489,285 over benefits paid during the first three quarters last year.

Benefits paid out on behalf of subscribers during the first nine months of 1966 amounted to 91.1 per cent of total subscription income. This is an increase over the 90.9 per cent paid during the first three quarters of 1965.

Subscription income during the first three quarters of 1966 increased $60,088,816 to a record high of $1,179,792,165.

Operating expenses were up a fraction of one per cent over the same period last year.

Otolaryngologic Assembly

The 1967 Otolaryngologic Assembly will be held at the Illinois Eye and Ear Infirmary at the Medical Center in Chicago, October 14-20.

The program is designed to bring to specialists current information on medical and surgical otorhinolaryngology.

Interested physicians should direct communications to: Department of Otolaryngology, P. O. Box 6998, Chicago, Illinois 60680.

PG Medical Education Survey Is Completed

The results of a medical education survey of all members of the West Virginia State Medical Association have been tabulated, and a report has been submitted to the Committee on Medical Education and Hospitals, which ordered the study.

Dr. Pat A. Tuckwiller of Charleston said the response to the survey, conducted in February, was outstanding and the results should give the Committee considerable guidance in planning its own program of continuing medical education.

The two-page questionnaire was mailed to 1,320 physicians, and 611, or more than 46 per cent, completed it and returned it to the headquarters office in time for tabulation. Several other questionnaires were returned too late to be counted in the survey.

Among some of the more interesting facts revealed by the survey were the following:

—Thirty-seven per cent of the responding physicians classified themselves as "family physicians."

—Almost six out of every 10 doctors are solo practitioners, and also 17 per cent are engaged in group practice.

—Approximately 96 per cent of the doctors have privileges in at least one hospital, and the majority are on the staffs of two or more hospitals.

—Almost one out of every three doctors residing outside Morgantown indicated they sometimes refer patients to the WVU Medical Center.

—Journals and books play an important part in the continuing education of virtually all physicians; four out of five obtain some of their medical education from component medical society meetings; and seven out of 10 attend out-of-state postgraduate programs regularly.

—Just under half of the responding physicians believe that cardiovascular disease should be emphasized in future medical education programs; respiratory disease was second with a rating of almost 36 per cent.

—Forty-eight per cent of the physicians said there should be more practical programs at the hospital and medical conventions.

Interested physicians may obtain a copy of the survey results by writing to Mr. William H. Lively, Executive Secretary, West Virginia State Medical Association, P. O. Box 1031, Charleston, West Virginia.

The Committee received and discussed the report at a meeting in Charleston on April 9.

Doctor Tuckwiller said that the Committee decided to conduct its first postgraduate program in Area 5 (Kanawha, Putnam, Boone, Fayette, Nicholas, Clay, Roane, Braxton and Webster Counties) sometime next fall. Dr. Edwin M. Shepherd, the Committee's coordinator for Area 5, will be responsible for arranging the program.

The Committee also instructed its seven other area coordinators to make plans for at least one program in their respective areas during the coming year.

Venereal Disease Rate Shows Increase

The incidence of venereal disease has continued to increase with people in the United States presently being infected with syphilis at a rate believed to exceed 10,000 cases a month. The gonorrhea rate is estimated at 8 to 10 times that of syphilis. The American Medical Association reports that every day, 1,500 United States teen-agers and young adults are infected with syphilis, gonorrhea or both. State Health Director N. H. Dyer reported these figures in a recent issue of the "State of the State's Health."

Doctor Dyer reminded West Virginians that venereal disease disregards racial, economic, and social barriers. "It is going up in society and down in age." he said. West Virginia recorded an alarming 376 per cent increase in reported cases of infectious syphilis between 1957 and 1966. In 1966, more than 80 per cent of the venereal disease cases reported in West Virginia were found in persons less than 30 years of age. Sixty-three per cent were under 25 and 32 per cent under age 20. The percentages for each of these age groups, Doctor Dyer noted, increased approximately 10 per cent since 1956.

During fiscal 1966, Doctor Dyer remarked, West Virginia's syphilis case rate per 100,000 population ranked eighth in the United States and exceeded the national average by 30 per cent. During the same period the congenital case rate ranked sixth.

About 39 of every 100 persons with untreated syphilis can be expected to suffer from some late destructive effects and 23 can be expected to die primarily as a result of the disease, Doctor Dyer said. Syphilis annually causes more deaths than do bone malignancy and lung cancer combined. West Virginia mental institutions list 234 patients who are suffering from psychosis due to syphilis. These patients represent an annual cost of approximately $250,000.

"It is a known fact that syphilis is hidden educationally and informationally," Doctor Dyer stated. "This has resulted," he said, "primarily from the philosophy of today's public, including many educators. This philosophy is: speak no VD, see no VD, hear no VD, and there shall be no VD."

Doctor Dyer reported two outbreaks of infectious syphilis among residents of several West Virginia counties to illustrate the tragic consequence of the "no VD" philosophy. Among the 254 West Virginia citizens involved, he said, 108 were teen-agers and a total of 169 was under age 25. "A definite lack of accurate venereal disease information permeated this group and resulted in persons failing to recognize obvious symptoms, failing to seek advice or proper medical help, exposing others to their infection," Doctor Dyer remarked. "It became very evident that apathy and ignorance are strong allies of venereal disease."

Doctor Dyer pointed out that information received from areas where venereal disease education has been introduced into the school curriculum is encouraging. These areas report that venereal disease rates among teen-agers who have received VD education have substantially decreased while rates among the total teen-age population continued to increase, he said. The percentage of patients who voluntarily sought treatment increased and the time difference between the appearance of disease symptoms and the seeking of treatment decreased. There are indications that VD education decreased promiscuity, Doctor Dyer said.

"If we are to create in each community, especially among young people, an awareness of the venereal diseases and the threat they pose to individual and community health," he said, "every citizen must take the initiative to become actively involved in dispersing the true facts about venereal disease."

Information regarding films, literature, and a new self teaching student text, accompanied by a guide for teachers relative to the venereal disease problem, is available upon request from the State Department of Health, Bureau of Venereal Disease Control.

An increasing incidence of infectious hepatitis in West Virginia during 1967 was predicted by Doctor Dyer in another issue of the "State of the State's Health."

Doctor Dyer said that the disease follows a cyclical trend with increasing incidences normally about every seven years. The peak of the last cycle occurred in West Virginia in 1961 when a total of 1,619 cases was reported. Concurrently, the U. S. Public Health Service reported a national record high of nearly 73,000 cases.

Many cases of hepatitis, particularly in younger age groups, Doctor Dyer said, occur with almost nonexistent symptoms or so minor that the patient does not seek medical attention. This accounts for many additional cases that are never reported. Unfortunately, these subclinical, unrecognized cases, he said, may be and often are the cause of many more cases. Doctor Dyer pointed out that it is common to note a rising incidence of hepatitis following a flood such as the one recently experienced and the attending insanitary conditions created.

Doctor Dyer said state and local health departments will continue intensive surveillance of infectious hepatitis throughout the coming months and will be available to provide epidemiological consultation and assistance in containing the expected rising incidence.

"Permanent Impairment" Guide Developed by AMA

The Committee on Rating of Mental and Physical Impairment of the American Medical Association has announced the availability of the tenth guide in a series entitled "Guides to the Evaluation of Permanent Impairment."

The latest in the series is called "Guides to the Evaluation of Permanent Impairment—Mental Illness."

The guide is designed primarily for use by physicians but is of interest to all persons concerned with the medical, administrative, or judicial aspects of programs for the disabled.

A limited number of copies of the new guide may be obtained without charge by writing to the Committee on Rating of Mental and Physical Impairment, 535 North Dearborn Street, Chicago, Illinois 60610.

100TH ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 24 - 26, 1967

CENTENNIAL YEAR 1867-1967

Pediatric Groups Merge In Morgantown

The West Virginia Pediatric Society and the West Virginia Chapter of the American Academy of Pediatrics have decided to merge.

The consolidation was voted at a joint business meeting of the two groups in Morgantown on March 24.

Dr. Forest A. Cornwell of Beckley, State Chairman of the West Virginia Chapter, American Academy of Pediatrics, said a constitution and by-laws were adopted unanimously. Non-fellows of the American Academy of Pediatrics will be accepted as affiliate members with essentially all privileges of Fellows except that affiliate members will not be eligible to serve as State Chairman or Alternate State Chairman.

Pediatricians attending the meeting decided to request that the West Virginia State Medical Association designate the West Virginia Chapter of the American Academy of Pediatrics as the Association's Section on Pediatrics. The old West Virginia Pediatric Society had been affiliated with the State Medical Association.

A complete new slate of officers for the new organization will be selected by secret mail ballot one month prior to the Annual Meeting, which will be held in White Sulphur Springs, August 24-26, in conjunction with the 100th Annual Meeting of the West Virginia State Medical Association.

Named to the Nominating Committee were Drs. George A. Shawkey of Charleston, Grover C. Hedrick, Jr., of Beckley, and Barbara Jones of Morgantown.

The next Spring Meeting will be held in Charleston.

The two-day meeting convened on Thursday afternoon, March 23. First on the program was a discussion of health and welfare programs, particularly as they apply to children. Participating were Mesdames Helen Condry and Ethel Cox, both of the West Virginia Department of Welfare; Dr. Emma Jane Freeman of the State Health Department in Charleston; and Dr. W. Gene Klingberg, Chairman of the Department of Pediatrics of the West Virginia University School of Medicine.

The business meeting on Friday morning was followed by a scientific session that afternoon. Participating were Drs. Roland E. Schmidt, Richard C. Juberg, Barbara Jones and Enid Gilbert, all of the WVU School of Medicine, and Dr. Warren D. Leslie of Wheeling.

Need a New Auto Emblem?

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $5.00 postpaid.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1967

May 2-3—Assn. of Am. Phys., Atlantic City.
May 3—Am. Cancer Soc., Dallas.
May 4-6—Am. Gynecological Soc., Phoenix.
May 6—Am. Col. of Psychiatrists, Philadelphia.
May 7-12—Am. Psy. Assn., Detroit.
May 11-14—Am. Surg. Assn., Colorado Springs.
May 16-19—Ohio Medical, Columbus.
May 28-June 1—Am. Dermatological Assn., Colorado Springs.
May 29-31—Am. Oph. Soc., Hot Springs, Va.
May 29-June 1—Am. Urol. Assn., New York.
May 21-24—Am. Thoracic Soc., Pittsburgh.

June 15-16—Am. Rheumatism Assn., New York City.
June 15-17—Am. Col. of Chest Phys., Atlantic City.
June 16-17—Am. Geriatrics Soc., Atlantic City.
June 17—Acad. of TB Phys., Atlantic City.
June 17-18—Am. Diabetes Assn., Atlantic City.
June 18-22—AMA Annual Con., Atlantic City.
June 22—Annual Preston County Meeting, Kingwood.

June 26-29—Am. Orthopaedic Assn., Hot Springs, Va.
July 14-15—Rocky Mtn. Cancer Conf., Denver.

July 23-29—Sou. Seminar in Ob. & Gyn., Asheville, N. C.

Aug. 21-24—Am. Hosp. Assn., Chicago.

Aug. 24-26—100th Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.

Aug. 27-Sept. 1—Am. Acad. of Phys. Med. & Rehab., Miami Beach.

Sept. 7-9—Am. Assn. of Ob. and Gyn., Hot Springs, Va.
Sept. 15-23—AAGP, Dallas.
Sept. 22-29—Col. of Am. Pathologists, Chicago.
Sept. 26-28—Ky. Medical, Louisville.
Sept. 27-30—Penn. Medical, Philadelphia.
Sept. 29-Oct. 1—W. Va. Heart Assn., Wheeling.
Sept. 29-Oct. 3—Am. Soc. of Anes., Las Vegas.

Oct. 2-6—ACS, Chicago.
Oct. 19-21—Va. Medical, Alexandria.
Oct. 20-24—Am. Heart Assn., San Francisco.
Oct. 21-26—Am. Acad. of Ped., Washington.
Oct. 29—Am. Assn. of Oph., Chicago.
Oct. 29-Nov. 3—Am. Acad. of Oph. and Otol., Chicago.

Nov. 13-16—Southern Medical, Miami Beach.
Nov. 25-26—Am. Col. of Chest Phys., Houston, Texas.
Nov. 26-29—AMA Clinical Meeting, Houston, Texas.
Nov. 29-Dec. 3—Am. Med. Women's Assn., Atlanta.

Dec. 2-7—Am. Acad. of Dermatology, Chicago.
Dec. 4-6—Sou. Surgical Assn., Hot Springs, Va.

1968

Jan. 17-18—Am. Rheumatism Assn., Baltimore.
Jan. 20-25—Am. Acad. of Orthopaedic Surgeons, Chicago.

Feb. 3-7—Am. Acad. of Allergy, Boston.
Feb. 6-10—Am. Col. of Radiology, Chicago.
Feb. 28-March 3—Am. Col. of Cardiology, San Francisco.

March 18-20—Am. Acad. of Ped., Atlanta.
March 24-29—Am. Col. of Allergists, Denver.
March 29-31—Am. Soc. of Int. Med., Boston.

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ew Optimil's superior nutritional ılance of major nutrients and their ›mponents provides highest caloric ficiency. Optimum protein and min-al content assures lowest renal ›lute load.

Optimil is recommended as regular feeding for optimum growth and development of normal newborns; as an ideal supplement to or replacement for breast milk; as sound nutrition for prematures; and as prophylaxis against both essential fatty acid and nutritional iron deficiency.

Optimil, diluted 1 to 1 with water, provides a standard feeding formula—20 calories per oz. Supplied in new, convenient 16-oz. cans, Optimil is available for your specification at leading drug stores.

The complete Optimil system available to hospitals includes: 5% Glucose Water in presterilized 4-oz. disposable bottles • Optimil 13 calories/oz. Prepared Formula in 4-oz. disposable bottles* • Optimil 20 calories/oz. Prepared Formula in 4-oz. disposable bottles* • Optimil Concentrated Infant Formula in 16-oz. cans • Sterilized disposable nipples • Optimil Gift Pack: six 4-oz. disposable bottles of Optimil 20 calories/oz. Prepared Formula* and one 16-oz. can of Optimil Concentrated Infant Formula.

**prediluted and sterilized*

1. Carson, M., and Hart, L.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," Colloquim held under the auspices of The Pediatric Department, Western Reserve University School of Medicine at Cleveland, Ohio, Sept. 8, 1966. Data available on request.

2. Hepner, R.: ibid. 3. Nichols, M.: ibid. 4. McCann, M.L.; Teree, T., and Wallace, W.; ibid.

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WVU Medical Center
—News—

DR. Thomas J. Tarnay, Assistant Professor of Surgery at the School of Medicine, has been appointed a Markle Scholar in Academic Medicine by the John and Mary R. Markle Foundation of New York.

Doctor Tarnay is one of 25 Markle Scholars designated this year. The Foundation will pay $30,000, at the rate of $6,000 a year for five years, to the School of Medicine. The money is to be used to supplement salary, aid research or otherwise assist in the development of the Scholar as a teacher or investigator.

Doctor Tarnay received his A. B. degree from Cornell University and his M. D. degree from the Columbia University College of Physicians and Surgeons.

Medical Fraternity Initiates 10

Nine medical students and a member of the faculty of the School of Medicine were initiated into Alpha Omega Alpha, national medical honorary fraternity, at the Medical Center on April 6.

The faculty member initiated was Dr. Robert J. Marshall, Professor of Medicine.

Fourth-year students inducted were: Larry Olen Harper and Jon Raymond Morgan, both of Morgantown; Albert J. Kolibash, Jr., of Benwood; Hugo J. McClung of Hartford, Mason County; Richard Henry Sibley of Nitro; and Robert K. Webb of Sistersville.

• Compiled from moteriol furnished by the Medicol Center News ond Informotion Services, Morgontown, West Virginio.

Third-year students inducted were Fred W. F. Holt and Ronald L. Wilkinson, both of Charleston; and Fred A. Brindle of Martinsburg.

The induction was conducted prior to the delivery of the annual Alpha Omega Alpha Lecture. The speaker was Dr. Richard B. Stark, plastic surgeon, medical historian, and a member of the staff of St. Luke's Hospital in New York City.

Faculty Promotions

Several members of the School of Medicine Faculty have received promotions, effective July 1, according to Dr. Harry B. Heflin, Acting President of the University.

Dr. Alvin L. Watne will be promoted from Associate Professor of Surgery to Professor.

Being advanced from Assistant Professor to Associate Professor are: Drs. Alphonse C. Edmundowicz, Roland E. Schmidt and John E. Jones, Medicine; and Dr. Enid M. Gilbert, Pathology.

To be promoted from Instructor to Assistant Professor are: Drs. Marilyn A. Jarvis and German Lizarralde, Medicine; Stancil E. D. Johnson, Psychiatry; and Naomi G. Kaplan, Pathology.

These physicians and lay people participated in the program for a joint meeting of the West Virginia Pediatric Society and the West Virginia Chapter of the American Academy of Pediatrics, which was held in Morgantown, March 23-24. From left to right are: Dr. W. Gene Klingberg of Morgantown, Chairman of the Department of Pediatrics at the West Virginia University School of Medicine; Dr. Forest Cornwell of Beckley, State Chairman of the West Virginia Chapter, American Academy of Pediatrics; Mrs. Helen Condry of the State Department of Welfare in Charleston; Dr. Emma Jane Freeman of the State Health Department, Charleston; Mrs. Ethel Cox of the State Department of Welfare; and Dr. James Gillespie of the American Academy of Pediatrics. (See story in General News Section).

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Card McGraw, Ph. D.
David F. Strahley, Ph. D.

Edward E. Cale, M. D.
Malcolm G. MacAulay, M. D.
Don L. Weston, M. D.
J. William Giesen, M. D.

Don Phillips, Administrator
R. Lindsay Shuff, M. H. A.
Asst. Administrator
Social Service:
Harold M. Cook, M.S.W.

AFFILIATED CLINICS

Bluefield Mental Health Center
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David M. Wayne, M. D.

Beckley Mental Health Center
109 E. Main Street, Beckley, W. Va.
W. E. Wilkinson, M. D.

Charleston Mental Health Center
1206 Quarrier St., Charleston, W. Va.
E. E. Gimenez, M. D.

Mental Health Clinic
Professional Building, Wise, Va.
Pierce D. Nelson, M. D.

The Month in Washington

• From the Washington Office of the American Medical Association.

THE American Medical Association favors utilizing Medicaid instead of expanding Medicare. Dr. Charles L. Hudson, AMA President, outlined the Association's position at a House Ways and Means Committee hearing on the Administration's bill, "Social Security Amendments of 1967" (H. R. 5710). He was accompanied by Dr. Milford O. Rouse, AMA President Elect.

"Available tax funds should be used to give maximum health care to those who need help," Doctor Hudson said. "Expenditure of public funds on those who do not need help limits the resources available to those who do need it. . . .

"We believe that a properly administered Title 19 (Medicaid) with realistic criteria of eligibility designed for economically disadvantaged persons, plus the encouragement and improvement of voluntary health insurance and prepayment plans for the solvent, provide the best approach to health care financing."

Doctor Hudson said AMA representatives would be glad to meet with the committee and other interested parties to hammer out a workable approach to solving the many complex problems in the Medicare program, particularly as concerns its Plan B.

Highlights of AMA Testimony

Section 125, to include the disabled.—The adoption of Section 125 . . . could change the direction of Medicare from a program for older persons to one aimed at various select categories . . . We believe Title 19 should be utilized for that purpose. We urge the Committee to reject this provision.

Section 127, including podiatry.—While recognizing the usefulness of podiatry services, we are impelled to note that if the amendment is adopted, the podiatrist could assume responsibility for the care of some of the more difficult problems in medicine. We believe this to be unsound.

Section 130, creation of Part C of Title 18.—This section would provide a new Part C to cover payment for hospital services rendered to hospital outpatient; and for diagnostic specialty services to both outpatients and inpatients of hospitals. The AMA opposes Part C *in toto*. . . .

Section 131, physician certification.—The AMA endorses Section 131 which would remove the requirement of a physician's certification for inpatient hospital care for each Medicare patient admitted to a general hospital. We urge the Committee to consider this amendment favorably and remove an unnecessary impediment to the operation of Part A.

We further urge that the requirement for re-certification be similarly deleted, since this need should be satisfied as a result of the work of utilization review committees.

Until re-certification is deleted, we suggest that the first certification date be the 20th day of hospitalization, as permitted in the existing law.

Section 220, income maximum under Title 19.—The AMA supports the concept of limiting eligibility for Title 19 benefits to persons who genuinely need financial assistance in meeting their health care needs.

Section 226, free choice under Title 19.—Although free choice is guaranteed for Title 18 recipients, a similar privilege was not extended to Title 19 beneficiaries. We believe this was an oversight, and we heartily support this perfecting amendment to Title 19.

Additional amendments proposed by the AMA.—First, the AMA recommends that Title 18 be amended to permit payment of charges for professional services on the basis of a physician's itemized statement of charges rather than a receipted bill.

Second, we recommend that Title 18 be amended to remove the requirement for three days of hospitalization before qualifying for extended care benefits.

In addition, we offer a recommendation relating to psychiatric care under Title 18.

Regarding Title 19, we offer six amendments.

First, that the program permit payment to the patient for services rendered to him by a physician on the basis of the physician's itemized statement of charges.

Second, that the program clearly provide for the payment of physician fees on the basis of his usual and customary charges, using the same approach as that applied under Title 18.

Third, that Title 19 encourage the use of insurance carriers in the implementation of state programs.

Fourth, that in the implementation of Title 19 programs, there be no requirement for certification or re-certification.

Fifth, that Title 19 permit all state plans to vary the eligibility standards within a state to recognize the very real differences in the cost of living in a rural area, a small town, a city or a metropolitan area.

Our sixth recommendation relates to the fact that Title 19 benefits differ for mentally ill patients depending on whether they are above or below age 65. We believe there should be no distinction in the services available to mentally ill patients.

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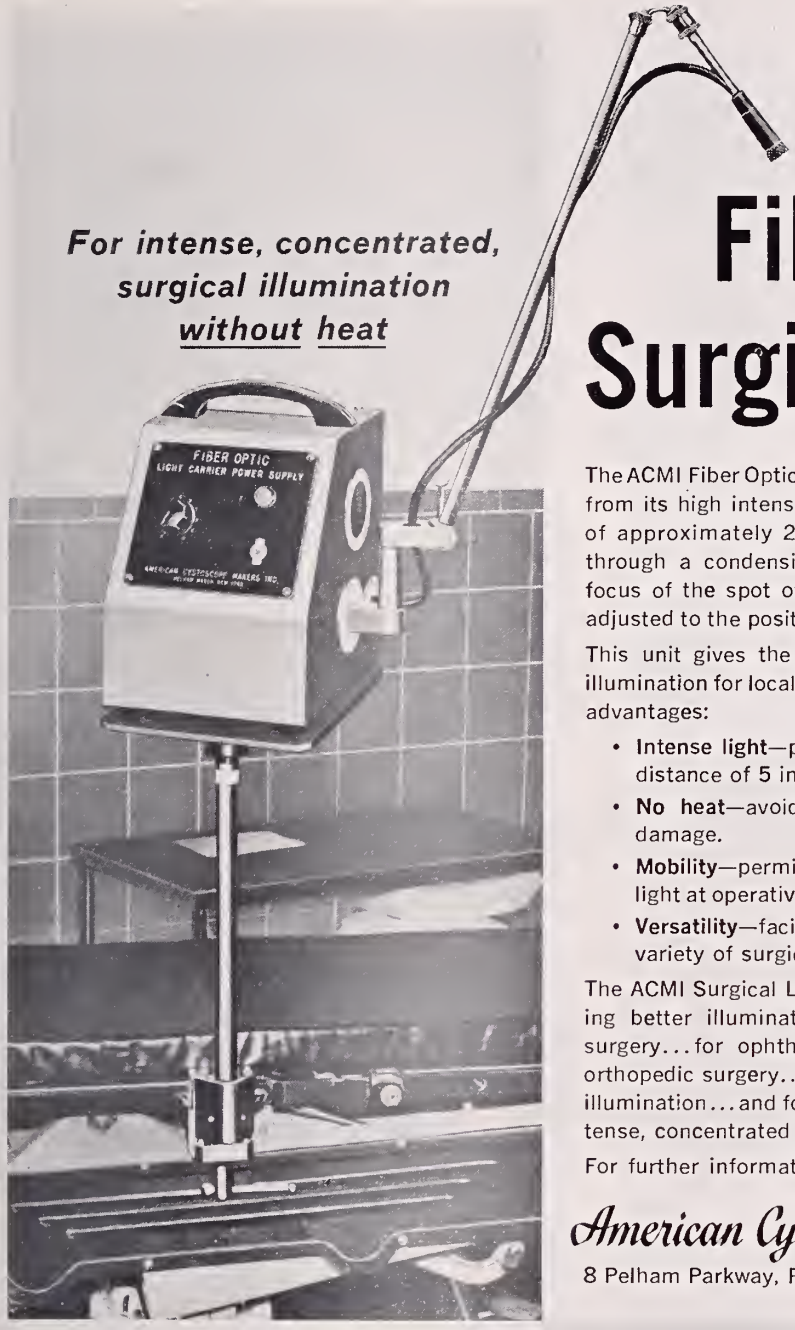

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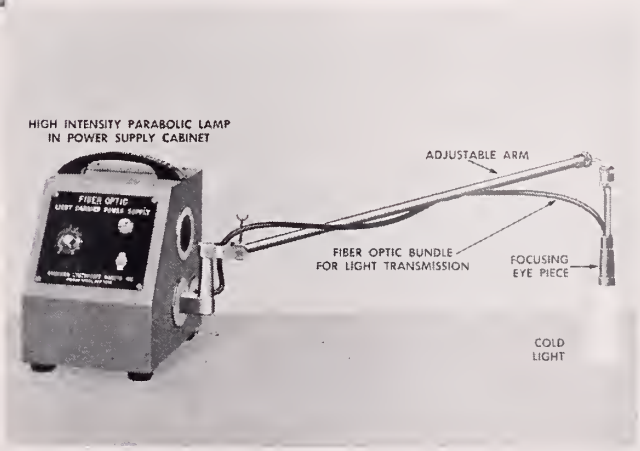
A table model (Catalog No. FO-5300) is available, as illustrated (right). A transformer in the power supply cabinet reduces voltage from 110 volts, 60 cycles AC, to 21 volts; and a Variac regulates this voltage supply from 0 to 21 volts, as required.

The power supply is not explosion proof and should be mounted 5 ft. off the floor in areas where explosive gaseous mixtures are used. A stand (Catalog No. FCB-100-S) which can be attached to the operating room table is available for this purpose (as illustrated above).

Additional light carrier bundles for special uses are also available, in 1/8, 1/4 and 3/8-inch diameter, in 72-inch lengths.



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Annual Audit, 1966

The annual audit of receipts and disbursements of the West Virginia State Medical Association for the calendar year 1966 has been completed by the firm of Fitzhugh, Erwin, McKee and Hickman, Certified Public Accountants of Charleston. The complete audit, with letter of transmittal, follows:

FITZHUGH, ERWIN, McKEE & HICKMAN
Certified Public Accountants
500 Kanawha Banking & Trust Building
Charleston, West Virginia 25301

West Virginia State Medical Association
Charleston, West Virginia

We have examined the summary statement of cash receipts and disbursements of the West Virginia State Medical Association and the statements of cash receipts and disbursements by funds for the year ended December 31, 1966, and the statement of securities owned at December 31, 1966. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying summary statement of cash receipts and disbursements and the statements of cash receipts and disbursements by funds present fairly the recorded cash transactions of the West Virginia State Medical Association for the year ended December 31, 1966, and securities owned by the Association at December 31, 1966.

FITZHUGH, ERWIN, McKEE & HICKMAN

Charleston, W. Va.
January 18, 1967

SUMMARY STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS CALENDAR YEAR 1966

CASH IN BANK—JANUARY 1, 1966		$ 21,203.86
RECEIPTS		
Dues—see footnote	$ 92,000.00	
Interest on U. S. Bonds	487.50	
Collection Commission on A.M.A. Dues	583.43	
Advertising	30,007.04	
Emblems sold	79.25	
Subscriptions	543.50	
Exhibit space sold	7,032.50	
Dues collected for A.M.A.—see footnote	50,332.50	
Interest on savings	291.60	
Repayments to Medical Scholarship Fund	500.00	
Contributions to Medical Scholarship Fund	1,855.00	
Contributions—other	1,285.00	
Refunds	1,475.35	
Employee contributions—Employee Benefit Plan	397.12	
Total Receipts		186,869.79
		208,073.65
DISBURSEMENTS		
General Fund	54,302.73	
Medical Journal Fund	37,640.94	
Convention Fund	12,424.78	
Dues forwarded to A.M.A.	50,332.50	
Medical Scholarship Fund	11,604.10	
Total Disbursements		166,305.05
CASH IN BANK—DECEMBER 31, 1966		$ 41,768.60

	1-1-1966	12-31-1966
Cash in bank—Savings Account	6,892.12	7,183.72
Cash in bank—Checking Account	14,311.74	34,584.88
Total	$ 21,203.86	$ 41,768.60

The Association at December 31, 1966, held undeposited dues for 1967 in the amount of $2,250.00 which are not reflected in this statement.

THE HARDING HOSPITAL

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JAMES L. HAGLE, M. B. A.
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GENERAL FUND

Statement of Cash Receipts and Disbursements
Calendar Year 1966

BALANCE—JANUARY 1, 1966		$ 12,523.97
RECEIPTS		
Dues (Allocated to General Fund)—see footnote	$ 77,625.00	
Interest on U. S. Bonds	312.50	
Collection Commission on A.M.A. dues	583.43	
Refunds—miscellaneous	329.54	
Refunds—A.M.A.	837.00	
Employee contribution — Employee Benefit Plan	397.12	
Contributions	1,285.00	
Total Receipts		81,369.59
		93,893.56
DISBURSEMENTS		
Salaries	27,692.50	
Office supplies and expense	3,682.96	
Office equipment and furnishings	189.05	
Office rent	3,348.75	
Library expense	40.17	
Telephone and telegraph	2,579.99	
Postage	1,792.19	
Travel	1,965.57	
Legal and auditing	526.50	
Legislative bulletins and expense	560.72	
Payroll taxes	899.07	
Unemployment tax	105.58	
Mimeographing	975.53	
Expense of Council and Committee meetings	5,192.97	
Miscellaneous expense	926.02	
Employee Benefit Plans	2,337.11	
Public information	822.94	
Dues and subscriptions	540.11	
Refund of dues	125.00	
Transfer of deficit from Public Service Fund	1,630.62	
Total Disbursements		55,933.35
BALANCE—DECEMBER 31, 1966		$ 37,960.21
Due from Medical Journal Fund	19,596.19	
Balance in General Fund checking account	18,364.02	
Fund Balance	$ 37,960.21	

The Association at December 31, 1966, held undeposited dues for 1967 in the amount of $1,012.50 which are not reflected in this statement.

MEDICAL JOURNAL FUND

Statement of Cash Receipts and Disbursements
Calendar Year 1966

BALANCE—JANUARY 1, 1966 (Deficit)		($16,693.85)
RECEIPTS		
Advertising	$ 30,007.04	
Emblems sold	79.25	
Subscriptions	543.50	
Refunds	83.81	
Dues allocated to Journal Fund—see footnote	4,025.00	
Total Receipts		34,738.60
		18,044.75
DISBURSEMENTS		
Salaries	7,265.00	
Printing	27,476.64	
Engraving	1,099.16	
Postage	957.56	
Emblems purchased	225.00	
Miscellaneous	617.58	
Total Disbursements		37,640.94
BALANCE—DECEMBER 31, 1966		
(Deficit)		($ 19,596.19)
Due General Fund	$ 19,596.19	

The Association at December 31, 1966, held undeposited dues for 1967 in the amount of $52.50 which are not reflected in these statements.

Blessed event?

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*As shown by *in vitro* studies.
1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.

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CONVENTION FUND

Statement of Cash Receipts and Disbursements Calendar Year 1966

BALANCE—JANUARY 1, 1966		$ 3,931.41
RECEIPTS		
Exhibition space sold	$ 7,032.50	
Dues (allocated to Convention Fund) see footnote	3,450.00	
Refunds: Convention Golf Tournament	225.00	
Total Receipts		10,707.50
		14,638.91
DISBURSEMENTS		
Supplies and labor	5,437.47	
Travel	883.42	
Expense of speakers	3,883.89	
Advance Convention Golf Tournament	250.00	
Reporting	415.00	
Miscellaneous	555.00	
Auxiliary Convention expense	1,000.00	
Total Disbursements		12,424.78
BALANCE—DECEMBER 31, 1966		$ 2,214.13
Balance in General Fund checking account	$ 2,214.13	

The Association at December 31, 1966, held undeposited dues for 1967 in the amount of $45.00 which are not reflected in this statement.

AMERICAN MEDICAL ASSOCIATION DUES

Statement of Cash Receipts and Disbursements Calendar Year 1966

BALANCE—JANUARY 1, 1966	None
RECEIPTS	
Dues collected for A.M.A.—see footnote	50,332.50
	50,332.50
DISBURSEMENTS	
Dues forwarded to A.M.A.	50,332.50
BALANCE DUE A.M.A.—DECEMBER 31, 1966	$ None

The Association at December 31, 1966, held undeposited dues for 1967 in the amount of $90.00 which was not reflected in this statement.

PUBLIC SERVICE FUND

Statement of Cash Receipts and Disbursements Calendar Year 1966

BALANCE STATE ASSESSMENTS— JANUARY 1, 1966 (Deficit)	($ 1,630.32)
Deficit transferred to General Fund on January 16, 1966 and made a part of that fund thereafter	1,630.32
BALANCE STATE ASSESSMENTS— DECEMBER 31, 1966	None

MEDICAL SCHOLARSHIP FUND

Statement of Cash Receipts and Disbursements Calendar Year 1966

BALANCE—JANUARY 1, 1966		23,072.95
RECEIPTS		
Dues (allocated to Medical Scholarship Fund) see footnote	$ 6,900.00	
Contributions	1,855.00	
Interest on U. S. Treasury Bonds	175.00	
Interest on savings account	291.60	
Repayments of scholarships	500.00	
Total Receipts		9,721.60
		32,794.55

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DISBURSEMENTS		
Scholarship installment	11,500.00	
Travel, printing and miscellaneous expense	104.10	
Total Disbursements		11,604.10
BALANCE—DECEMBER 31, 1966		$ 21,190.45
Balance in Savings Account	7,183.72	
Balance in General Fund Checking Account	14,006.73	
Fund Balance	$ 21,190.45	

The Association at December 31, 1966, held undeposited dues for 1967 in the amount of $90.00 which was not reflected in this statement.

SCHEDULE OF BONDS OWNED AS OF DECEMBER 31, 1966

	Serial	Due Date	Maturity Value
U. S. Treasury 2½%	27846F	12-15-67/72	$10,000.00
U. S. Treasury 2½%	70011A	12-15-67/72	1,000.00
U. S. Treausry 2½%	70012B	12-15-67/72	1,000.00
U. S. Treasury 2½% (Medical Scholarship Fund)	72361A	12-15-67/72	1,000.00
U. S. Treasury 2½%	22646F	12-15-67/72	500.00
U. S. Treasury 2½% (Medical Scholarship Fund)	6873C	9-15-67/72	5,000.00
U. S. Treasury 2½% (Medical Scholarship Fund)	18939K	9-15-67/72	1,000.00
Series "J"	Q22297J	1- 1-1968	25.00
Series "J"	Q22298J	1- 1-1968	25.00
Total			$ 19,550.00

COMPARATIVE SCHEDULE OF FUND BALANCES AND BONDS AS OF DECEMBER 31, 1965 AND 1966

FUND BALANCES	12-31-65	12-31-66	Increase (Decrease)
General Fund	$12,523.97	$37,960.21	$25,436.24
Medical Journal Fund (deficit)	(16,693.85)	(19,596.19)	(2,902.34)
Convention Fund	3,931.41	2,214.13	(1,717.28)
A. M. A. Dues	—	—	—
Public Service Fund (deficit)	(1,630.62)	—	1,630.62
Medical Scholarship Fund	23,072.95	21,190.45	(1,882.50)
Total Fund Balances	21,203.86	41,768.60	20,564.74
U. S. BONDS (at cost)	18,621.92	18,621.92	—
TOTAL FUND BALANCES AND BONDS	$39,825.78	$60,390.52	$20,564.74

ACP Lists May PG Courses

The American College of Physicians will conduct three postgraduate courses during May.

The dates, subjects and locations are as follows:

May 8-12—"Clinical Ausculation of the Heart," Washington, D. C.

May 15-20—"Recent Advances in Clinical Endocrinology," Seattle, Washington.

May 22-25—"Clinical Applications and Recent Advances in Electrophysiology of the Heart," New York City.

Registration fees include $60 for members of the ACP and $100 for nonmembers.

Additional information may be obtained by contacting Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

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R. R. RAUB, M. D.

Neurosurgery:
E. L. GAGE, M. D.
WM. F. HILLIER, M. D.

Urology:
T. B. BAER, M. D.

Eye, Ear, Nose & Throat:
F. D. WHITE, M. D.
A. J. PAINE, M. D.

PEDIATRICS
GRADY McRAE, M. D.

OBSTETRICS & GYNECOLOGY
E. W. McCAULEY, M. D.
CHARLES S. FLYNN, M. D.
FREDERICK T. EDMUNDS, M. D.

INTERNAL MEDICINE
J. R. SHANKLIN, M. D.
KARL E. WEIER, M. D.
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C. D. PRUETT, M. D.
R. O. ROGERS, JR., M. D.

PATHOLOGY
DAVID F. BELL, JR., M. D.
JOHN J. BRYAN, M. D.

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S. G. DAVIDSON, M. D.

ANESTHESIOLOGY
DAVID H. GATHERUM, M. D.

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Obituaries

CHARLES A. HAISLIP, M. D.

Dr. Charles A. Haislip, 49, a practicing physician in Grafton since World War II, died on March 28 while vacationing in St. Petersburg, Florida.

A native of Grafton, Doctor Haislip received A.B. and B.S. degrees from West Virginia University. He received his M.D. degree in 1942 from Rush Medical College. He took postgraduate work in anesthesiology.

He served for more than two years in the U. S. Army Medical Corps during World War II.

Doctor Haislip was Chief of Staff at Grafton City Hospital at the time of his death. He was a member of the Taylor County Medical Society, of which he was twice President; the West Virginia State Medical Association; and the American Medical Association.

He is survived by his widow, Mary Elizabeth Haislip; a daughter, Nancy Lee Haislip, a student at the School of Nursing of West Virginia University; two sons, Dr. Charles M. Haislip of St. Petersburg, and Bruce Haislip, a student at the WVU School of Dentistry; three brothers, Harold of Cumberland, Maryland, Robert of Harmon, Maryland, and Wilbur of Baltimore; and three sisters, Mrs. Sarah Bartlett of Glen Dale, Mrs. Gladys Emerson of Washington, D. C., and Mrs. Beatrice Kehrer of Arlington, Virginia.

* * * *

ALBERT DAVID KISTIN, M. D.

Dr. Albert D. Kistin of Beckley, immediate Past President of the West Virginia Heart Association, died of an apparent heart attack on March 22. He was 59

Doctor Kistin collapsed and died shortly after alighting from a train at the Prince railroad station, near Beckley. He was returning home from the Washington, D. C., area, where he had lectured on cardiology.

A native of Paris, France, Doctor Kistin received A.B. and M.A. degrees from Cornell and Columbia universities before receiving his M.D. degree in 1935 from Rush Medical College. He interned at Mt. Sinai Hospital in New York City and took residency training at Montefiore Hospital in that same city.

During World War II, Doctor Kistin served as a Captain in the U. S. Army Medical Corps. He was a Diplomate of the American Board of Internal Medicine, a Fellow of the American College of Physicians, and a Fellow of the Council on Clinical Cardiology of the American Heart Association.

His other memberships included the Raleigh County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Doctor Kistin had been a resident of Beckley since 1955. In previous years, he served as Assistant Clinical Professor of Medicine at the George Washington University School of Medicine. At the time of his death, he was a Special Lecturer in Cardiology at that school.

Survivors include the widow, Mrs. Ruth Ulman Kistin; a son, Martin, a student at Cornell; a daughter, Naomi, a student at the George School in Pennsylvania; and one brother, Marcel, of Boston, Massachusetts.

* * * *

RICHARD N. O'DELL, M. D.

Dr. Richard N. O'Dell, 52, of Charleston, died in a hospital in that city on April 10 after a long illness.

A native of Gallipolis, Ohio, Doctor O'Dell received his pre-medical training at Marshall University. He attended West Virginia University and received his M.D. degree in 1937 from the Medical College of Virginia. He served an internship and residency at Charleston General Hospital, where he was a former Chief of Medicine.

He was Acting Chief of Staff of Thomas Memorial Hospital in South Charleston and was a Diplomate of the American Board of Internal Medicine. During World War II, he served for three years as a medical officer with the rank of Captain.

He was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association. His other professional memberships included the Pan-American Medical Association, the West Virginia and American Heart Associations and the International Geriatrics Association.

Survivors include the widow, Mrs. Vera O'Dell; a daughter, Verajane, at home; sons Bill, at home, and Larry, a student at West Virginia University; the mother, Mrs. Alma C. Withrow of Charleston; and a brother, Dr. Morris H. O'Dell of Charleston.

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*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

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County Societies

MONONGALIA

Dean Paul Selby of the West Virginia University School of Law was guest speaker for the regular monthly meeting of the Monongalia County Medical Society, which was held on March 7.

A question-and-answer period followed Dean Selby's discussion of "The Doctor in the Court Room."

Thirty-three members of the Society attended the meeting—Robert Greco, M. D., Secretary.

* * * *

MERCER

Dr. Richard Juberg, Associate Professor of Pediatrics at the West Virginia University School of Medicine, was guest speaker at the regular monthly meeting of the Mercer County Medical Society, which was held at the West Virginian Hotel in Bluefield on March 20.

Doctor Juberg discussed genetic counselling, and he presented some case histories.

The Society decided to donate $80 to Camp Kno-Koma, a summer camp for diabetic children.—John J. Mahood, M. D., Secretary.

Heart Association Arranges Cardiology Courses

Postgraduate courses entitled "Three Days of Cardiology," co-sponsored by the American Heart Association's Council on Clinical Cardiology, local Heart Association affiliates and medical schools, have been scheduled for 1967 as follows:

May 8-12: Atlanta, "Cardiology Today" (extended to five days because of the nature of the course) directed by Dr. J. Willis Hurst, co-sponsored by Georgia Heart Association and Emory University School of Medicine;

September 18-20: Boston, "Congenital Heart Disease Problems," directed by Dr. Alexander S. Nadas, co-sponsored by Massachusetts Heart Association;

November 30-December 3: St. Petersburg, Fla., "Electrocardiographic Diagnosis of Arrhythmias," directed by Dr. Henry J. L. Marriott, co-sponsored by Florida Heart Association.

Registration fees for the three-day courses are $50 for Members and Fellows of the Council on Clinical Cardiology and $85 for non-members.

Registration forms and additional information may be obtained from the West Virginia Heart Association, 759 West Washington Street, Charleston, West Virginia 25302.

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Parliamentarian: Mrs. D. E. Greeneltch, Wheeling

CABELL

The Woman's Auxiliary to the Cabell County Medical Society held a "Bonnet Buffet" at the Huntington Woman's Club on March 10.

After a luncheon, 75 spring hats were modeled by women of the Auxiliary.

About 400 women attended, and proceeds were earmarked for AMA-ERF.

★ ★ ★ ★

HARRISON

Members of the Woman's Auxiliary to the Harrison County Medical Society honored their husbands with a dinner-dance in observance of "Doctors Day" at the Clarksburg Country Club on March 11.

Mrs. Albin A. Galuszka, President of the Auxiliary, welcomed the doctors and introduced Dr. James A. Thompson, President of the Harrison County Medical Society. Mrs. Joseph Gilman was chairman of the committee which handled the arrangements.

More than 90 persons attended the event.

★ ★ ★ ★

McDOWELL

The regular monthly meeting of the Woman's Auxiliary to the McDowell County Medical Society was held March 8 at the home of Dr. and Mrs. John H. Murry in Gary.

Guest speaker was Mr. Wade Watson of Gary, Assistant Prosecuting Attorney of McDowell County. He discussed the Child Abuse Law passed by the Legislature two years ago. A question-and-answer period followed.

Twelve members and guests attended the meeting.

★ ★ ★ ★

MONONGALIA

Prof. Londo H. Brown of the West Virginia University College of Law was guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Monongalia County Medical Society, which was held at the Hotel Morgan in Morgantown in March.

Professor Brown's topic was "Estate Planning."

More than 24 members and guests attended.

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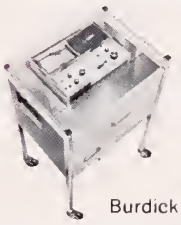

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Book Reviews

BIOLOGICAL TREATMENT OF MENTAL ILLNESS—Edited by Max Rinkel, M. D., Medical Director of the Manfred Sakel Institute, New York, N. Y. Pp. 1025, with numerous illustrations. 1966. L. C. Page & Company, a division of Farrar, Straus and Giroux, 19 Union Square West, New York, N. Y. 10003. Price $25.00.

This book is of general medical interest because of the emphasis on the biochemistry, endocrinology, physiology, etiology and treatment of mental disorders, especially schizophrenia. It is very technical. It is not recommended for the non-psychiatrist. It should be in the hospital library and be available as a reference book if for no other reason than to demonstrate that some psychiatrists still think that the psyche has an organic, physical, living origin and is not just an abstraction.

Although biological treatment is condemned in many circles, the reader of this book will realize that most of the advances in the treatment of major mental illnesses in the twentieth century have been biological. Some of the authors offer some tantalizing biological hypotheses of mental illness that may lead to a major breakthrough in the future.—David H. Smith, M. D.

★ ★ ★ ★

CLINICAL MANAGEMENT OF BEHAVIOR DISORDERS IN CHILDREN—By Harry Bakwin, M. D., Professor of Clinical Pediatrics, N. Y. University; Ruth Morris Bakwin, M. D., Professor of Clinical Pediatrics, N. Y. University. W. B. Saunders Company, Philadelphia, London. 1966. Illustrated. Pp. 652. Price: $14.50.

This is a book that can be of use in any physician's bookshelf. It has the merit of being couched in simple language. The authors avoid psychiatric jargon. It is not a psychiatric text but rather a fundamental text of medicine in the broad sense of the term.

Just as a knowledge of histology, embryology and physiology are essential to an understanding of pathology, the authors are aware of the importance of genetics, heredity, biology and sociology to the understanding of psychopathology. Behavior disorders are seen as a disturbance in the growth and development in the total context of nature and nurture. At the end of each chapter is a reference list. There is a subject index and an author index. This book is highly recommended.—David H. Smith, M. D.

* * * *

CONFLICT IN SOCIETY-Ciba Foundation Symposium—By Anthony DeRueck, M. Sc., D.I.C. A. R. C. S.; Julie Knight, B. A.; Little Brown & Company, Boston. 1966. Pp. 467. Illustrated. Price: $13.00.

This book is one of 60 symposia sponsored and published by the CIBA foundation. The essays make difficult reading in aggregate, as is to be expected of a set of articles at the graduate level in social sciences. The day is gone when behavioral science essays resemble Sunday supplement articles. The reader will note the methodology of each of the academic areas represented is presented as if the reader is more or less familiar with the method of the presenter.

The essays represent the "state of the art" of the behavioral sciences, all related to a most relevant probelem "conflict in society." Moreover, from the discussions between the participants, it is evident that conflict resolution was a constant task for these professors among themselves. But then, the colloquiam is one of our best formal devices for conflict resolution not only in "group therapy" but also in faculty meetings and peace arbitration so that the book is an example of conflict in our society as well as an exposition.

Washburn's essay, "Conflict in Primate Society," is a sober and comprehensive introduction and reviews our present knowledge of territoriality, hierarchy control, and reproductive patterns in mammals. He argues that generally order is maintained in mammalian groups of hierarchical organization. The space between groups is divided by habit and conflict. The aggressive individual is the essential actor within the social system and competition is necessary for the distribution of the species and the control of local population.

M. R. A. Chance points out that intra-species aggression is structured in mammals and ordinarily resolved without lethal combat.

George de Vos attempts to trace the evolution of aggression in social-psychiatric terms. He attacks the utopian error in Marxist thinking regarding exploitation of one social class by another.

H. V. Dicks discusses the impact of authoritarian leaders, such as Adolph Hitler, showing that attitudes of bigotry in a general population tend to support authoritarian leaders.

J. A. A. Van Doorn discusses the conflict in formal organizations, such as the Church and business establishments. He offers three models—the sect, the coalition, and the dichotomy—as heurtistic devices.

Ruth Glass points out that conflict in cities is not directly correlated with size, contrary to popular mythology.

A. Barbu seeks to correlate nationalism with aggressive traits.

H. Lasswell presents a cogent argument for the reciprocal relationship between the leader and the led, the aggressor and the victim, using examples from law rather than psychiatry.

K. E. Boulding graphs the vector of a hypothetical conflict system, maps areas corresponding to typical "discussions" and contends that conflict leads to learning. This point was contended by others who pointed out to several situations wherein getting hurt does not lead to cessation of conflictual activity.

Anotal Rapoport presents two models of conflict, a "cataclysmic" model and a "strategic" model, the latter suggestive of Berne's "Games People Play."

Karl Deutsch attempts a delineation of the forces and lines of communication that relate national powers, attempting, as have the other authors, to abstract the process of international relations rather than simply record history.

B. V. A. Roling discusses the role of Law in conflict resolution after the fashion of modern Sociology.

Karol Lapter seeks to review psycho-social determinants of international tension.

This book is dedicated, in essence, to the Bomb. It asks, "Can a group of distinguished behavioral scientists provide solutions to social conflicts already raging?" The answer is a qualified "no," but not a pessimistic "no." It closes with a quotation from William Randal Cremer (1908):

"Gentlemen, there is still a great work before us. The Advocates of Peace are, however, no longer regarded as idle dreamers, and I trust that I have convinced you that our cause has, especially of late, made wonderful progress, and that we are nearing the goal of our hopes. The World has passed through a long night of tribulation and suffering, millions of our fellow creatures have been sacrificed to the demon of War, their blood has saturated every plain and dyed every ocean.

"But courage, friends, courage! The darkness is ending, a new day is dawning, and the future is ours . . ."
—Robert L. Vosburg, M. D.

Sex Education Expert To Speak To AMA Auxiliary

Dr. Mary Calderone, noted proponent of sex education, will be one of the featured speakers at the 44th Annual Convention of the Woman's Auxiliary to the American Medical Association. The meeting will be held June 18-22 in Atlantic City concurrently with the Annual Convention of the AMA.

Mrs. Asher Yaguda of Newark, New Jersey, President of the AMA Auxiliary, said Doctor Calderone's address will be on Tuesday morning, June 20. Her subject will be "Sex Education: Goals and Means."

Dr. Charles L. Hudson of Cleveland, President of the AMA, also will address the Auxiliary on Tuesday. Doctor Hudson will speak at a luncheon honoring past presidents of the Auxiliary and AMA officers and trustees.

Mrs. Yaguda and Mrs. Karl F. Ritter of Lima, Ohio, President Elect, will be honored at a reception on Sunday, June 18. Mrs. Ritter will be installed as President on Wednesday, June 21.

Other Convention highlights will be a Guest Day Luncheon on Monday, with the speaker to be announced, and a "Little Workshop," which will consist of a question-and-answer session on Auxiliary programs.

The Auxiliary also will sponsor a program for children of physicians and wives attending the AMA and Auxiliary sessions.

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Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

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William K. Kalbfleisch, M. D.

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The wise, and presumably safe, use of a drug depends largely on the education, training, experience and judgment of the prescriber. And to an important extent it also depends on the wisdom of the patient as he follows instructions.—Austin Smith, M. D., in *Experimental Medicine and Surgery.*

Functions of Medical Journals

In describing their present functions I have crudely distinguished two types of journal, the recorder and the newspaper, with an intermediate type, the newspaper-recorder, which tries to be both.

The recorder journal exists mostly for the benefit of the writer, who wants his work to be known and who wants the details to be on record so that fellow-experts can assess or repeat it. Such journals select only a proportion of the material they receive, and they may shorten what they select. But fundamentally the job of the editor—usually a part-timer—is that of organization: his office sees that each paper is read by one, two, or three advisers, each of whom fills in a form; and, if accepted, the paper is further processed for press. Admittedly the editors of some recorder journals do not confine themselves to organization: they happen to be artists who cannot bear to see inferior craftsmanship under their auspices and therefore spare no pains in polishing papers so that these shall be good to read. But if the papers are not in fact intended to be read—or only by very few—are not these artist editors wasting their time? Perhaps indeed the printers, too, are wasting *their* time? Could not many of the papers which fill our recorder journals reach their proper readers in some other form?

Whereas the function of the recorder journal is solely to advance knowledge, the function of the newspaper journal is more complex. By stimulating discussion it, too, may advance knowledge; but usually it is mainly concerned with advancing practice. If it is a journal for clinicians, its task may be to supply and interpret the kind of information that will help doctors to help patients; to encourage useful reforms both in medical institutions and in medical practice; and to hold the profession together by keeping every sort of doctor in touch with what the others are doing. Whereas the selection and recording of scientific information is, I suggest, essentially a matter of *organization,* best undertaken on an ever-larger and more comprehensive scale, a newspaper journal can be positively harmed by becoming big and organized—especially if its bigger size makes it more orthodox. Unlike the recorder, the newspaper requires all the editorial skill it can get; and the routine imposed on its editors should not be so heavy as to weaken them for their real task. That task, as I have said, is to enlighten and enliven.—Sir Theodore Fox, *Crisis in Communication,* The Athlone Press, London, 1965.

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AVAILABLE—Lucrative general practice. Minimal investment necessary for right person. Equipment and air-conditioned clinic building available if wanted. Leaving for residency in June. Primary aim is to provide good medical care for my patients. Community is growing and prosperous. Hospital facilities available. Contact S. M. Lilienfeld, M. D., 229 Walnut Street, Parsons, W. Va. Phone 478-2221.

GENERAL PRACTITIONER—Internist or specialist. Excellent opportunity. Rent office in medical building close to hospital. Morgantown, W. Va. Write LKC, The W. Va. Medical Journal, Box 1031, Charleston, W. Va. 25324.

WANTED—Excellent opportunity for general practitioner in Glenville, W. Va. Citizens of the community will provide medical facility, local financing and assistance in acquiring housing. Part-time services needed at Glenville State College with equipped infirmary and guaranteed salary. Hospital within 20 miles, new hospital to be constructed 28 miles away. Many recreational facilities available. Contact Mr. Donald L. Fogus, Glenville State College, Glenville, W. Va. Phone 462-8335.

WANTED—A general practitioner to locate in the growing town of Fort Ashby (Mineral County) West Virginia, situated to serve the communities of Short Gap, Springfield and Green Spring. Excellent opportunity for an ambitious physician. For information on possible assistance in establishing office facilities, contact Doctor Committee, Fort Ashby Lions Club, Fort Ashby, W. Va. 26719.

PHYSICIAN WANTED — An experienced general practitioner to add to and work with an established salaried group in metropolitan area. This provides regular hours and minimal night work. Contact Charles E. Staats, M. D., 123 West Washington Street, Charleston, W. Va. 25302.

WANTED IMMEDIATELY—A general surgeon for a modern 40-bed well-equipped hospital. We have five general practitioners on the medical staff who do not practice surgery and will refer to a qualified surgeon. Income limited only by desire and ability. Write or call Administrator, Hampshire Memorial Hospital, Romney, W. Va. 26757. Phone 304-822-3514.

URGENT NEED—Excellent opportunity for general practitioner. Hospital facilities, office space and housing available. Contact: Sutton General Hospital, Inc., 307 Main Street, Sutton, W. Va. 26601.

GENERAL PRACTITIONER—For long established medical practice. Gross $50,000. Excellent hospital. Little night work. Opportunity for young doctor. Immediate income from industrial arrangement. Write CLA, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

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MARSHALL UNIVERSITY seeks Director of University Health Service. Mostly clinical work but some administrative duties. Maximum latitude to develop excellent medical service. Contact: Dean John E. Shay, Jr., Marshall University, Huntington, W. Va. 25701.

AVAILABLE—Board eligible anesthesiologist. Thirty-eight years old. University trained and experienced. Desires private practice and fee for service arrangement. Will consider heading department or setting up a department of anesthesia. Write HPN, The W. Va. Medical Journal, Box 1031, Charleston, W. Va. 25324.

AVAILABLE—Board eligible general surgeon desires location or association in West Virginia. Catholic, married with family, available January 1, 1967. Write REW, The W. Va. Medical Journal, Box 1031, Charleston, W. Va. 25324.

AVAILABLE—General surgeon, age 39. Desires to relocate in area near modern hospital where really needed. Prefer practice limited to surgery. Write LSC, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

WANTED—Ohio River community needs young general practitioner. Open staff, accredited hospital 15 minutes away. Assistance and office space available. Contact Mr. Lewis E. Summers, New Haven, W. Va. Phone 882-2128 collect.

WANTED—Elderly physician to live in small hospital in pleasant community. Minimum professional duties. Write OAR, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

WANTED—Young physician to take over practice of recently deceased physician. Excellent opportunity in an industrial community in Southern West Virginia. Many advantages. Write CPW, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

AVAILABLE—Anesthesiologist wishes to relocate. Board eligible, West Virginia license. Will consider all openings. Write NBL, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

RESIDENCIES AVAILABLE — Resident positions available in the following: First and second year positions of a fully accredited four-year general surgery residency. One position available in the first year and one available in the second. Phone or write to the Director of Medical Education, Memorial Hospital, Charleston, W. Va. 25304.

WANTED—Two general practitioners and a pediatrician to locate in a rapidly growing and extremely progressive community; excellent recreational facilities; within driving distance of the larger metropolitan areas; modern 45-bed general hospital, fully equipped and staffed; qualified general surgeon in residence. Write HRL, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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JUNE
1967

Vol. 63 No. 6

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston, W. Va. 25324

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50c per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

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The West Virginia Medical Journal

Vol. 63, No. 6 June, 1967

A Surgical Approach to the Management Of Chronic Relapsing Pancreatitis*

Colin G. Thomas, Jr., M. D., and Harry A. Wellons, Jr., M. D.

Disorders of the pancreas have remained something of a diagnostic and therapeutic enigma when considered among the more common diseases of the gastrointestinal system. Particularly is this true of inflammatory conditions of the pancreas in which not only are etiologic mechanisms obscure but, because of the paucity of objective findings, the diagnosis must be made primarily by careful evaluation and interpretation of the clinical symptoms. Physical findings are of aid chiefly in excluding other diseases. Laboratory examinations may be helpful but are too infrequently diagnostic. Radiologic examinations may identify opacities within the pancreas, displacement of the viscus from its usual position, or changes in duodenal mucosa. Angiograms are of value in demonstrating a mass lesion of the pancreas but the angiographic diagnosis of pancreatitis rarely is possible.[1] Isotope techniques for pancreatic delineation have, in general, been disappointing.

As in any disease in which the etiology and pathogenic mechanisms are obscure, treatment is likely to be empirical and poorly standardized. The many operations that have been proposed for patients with chronic pancreatitis are evidence of dissatisfaction with any one surgical procedure. In the past the emphasis has been placed upon the results of a particular approach rather than adaptation of the treatment to the pathologic findings. As a consequence, there are few clear-cut indications for a particular operative procedure. Perhaps some of the reluctance to advise surgical treatment has been related not only to poor results but also to the lack of a rational approach. It must be recognized that the pathologic changes accompanying chronic pancreatitis usually are irreversible and that it is a progressive disease. Too frequently patients have been operated upon relatively late in the course of the disease at which time, despite the relief of pain, there are irremedial physical and psychological changes resulting in continued invalidism due to chronic malnutrition, alcoholism or narcotic addiction. An attempt should be made to differentiate between several types of pancreatitis and even though etiological relations are poorly understood, surgical treatment should be based upon pathologic findings.

Clinically, patients with chronic relapsing pancreatitis seem to fall into three categories: (1) chronic pancreatitis and associated biliary tract disease, i.e. cholelithiasis or choledocholithiasis. The biliary tract disease may or may not be overt but the clinical story is more likely to be that of recurring attacks of acute pancreatitis with mild intermittent jaundice. Transient hyperamylassemia may occur. In such patients with a "normal" cholecystogram, the four-day opacification test may help identify calculi.

The natural history of this disease is that of continued acute attacks, some of which may be

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*Presented by Doctor Thomas before the Annual Meeting of the West Virginia Chapter of the American College of Surgeons at The Greenbrier in White Sulphur Springs, April 14-16, 1966.

Submitted to the Publication Committee, October 31, 1966.

quite fulminating. Rarely is there progression to calcification, pancreatic duct obstruction and insufficiency that is so characteristic of pancreatitis associated with alcoholism.[2,3] In general, patients with biliary tract disease are more likely to be a decade or so older than patients with other types of pancreatitis. The results of surgical management early in the course of the disease are excellent and early treatment will serve to preclude the morbidity from recurring acute attacks.

(2) Chronic Pancreatitis and Associated Alcoholism.—These patients are likely to be somewhat younger than those of the preceding group, with a predominance of men. Pain is more likely to be chronic in character with recurrent exacerbations. The disease is progressive, with the ultimate development of pancreatic fibrosis, calcification and insufficiency. The mechanism by which alcohol seems to produce pancreatitis is obscure but the relation seems well established. Early in this form of disease, there occurs obstruction of the finer ducts by a gel thought to be a precursor of calcification.[3] Acini and ductules dilate distal to this point resulting in sclerosis. When major duct obstruction develops, the process spreads to the entire organ. Although pancreaticolithiasis may occur in other circumstances, it seems to represent an advanced stage of the inflammatory process. In approximately 50 per cent of cases, patients with chronic alcoholism and associated pancreatitis will have pancreaticolithiasis.

(3) Chronic pancreatitis in which the associated etiologic factors are unknown, obscure, or infrequent, e. g., hyperparathyroidism, hyperlipemia, trauma, juvenile or familial types. Pancreatic cancer needs also to be considered since tumors near the pancreatic duct commonly produce obstruction. The inflammatory lesions and inexorable progress of the disease are comparable to what is seen in inflammatory pancreatitis.[4] Furthermore, pancreatic cancer has an increased incidence in chronic pancreatitis.

Surgical Treatment.—Surgical therapy, in general, has been based on the thesis that the symptoms in chronic pancreatitis are secondary to pancreatic duct obstruction and identification of the mechanism of such obstruction is essential to the selection of appropriate therapy. Stenosis of the main pancreatic duct rarely is the initiating factor; when present, however, intraductal pressure is increased and probably the cause of pain. Efforts to decompress the obstructed duct, therefore, are required to provide symptomatic relief though rarely curative insofar as progression of the pancreatitis is concerned. An exception to this may be those rare individuals who have stenosis of the terminal portion of the duct of Wirsung or the ampulla of Vater.[3,5] In many circumstances major pancreatic duct obstruction may not be present or the disease diffusely involves a major segment of the pancreas or the entire structure, with multifocal involvement of many small ducts. This type of problem would seem better treated by partial pancreatectomy than by drainage of the pancreatic duct.

In keeping with the above-mentioned principles of treatment, selection of the surgical procedure has depended upon the pathologic findings, viz, (1) correction of biliary tract disease and prevention of pancreatic duct reflux, (2) appropriate and adequate drainage of an obstructed pancreatic duct or (3) in the absence of major duct obstruction subtotal or partial pancreatectomy for diffuse or localized disease.

Timing of Surgical Treatment.—In general, patients with associated cholelithiasis or with recurrent attacks of acute pancreatitis suggestive of choledocholithiasis should have early elective surgery. In the absence of demonstrable biliary calculi prior to celiotomy, the chief problem is one of diagnostic accuracy and it may not be possible to substantiate suspicion of choledocholithiasis until the operative procedure. Patients with pancreatitis associated with chronic alcoholism or due to an obscure etiology with or without pancreatic calcification should have an initial trial on a medical regimen. Such a regimen consists of abstinence from alcohol and is designed to provide minimal pancreatic stimulation—basically the same regimen as for the management of chronic peptic ulcer. Rarely is such a regimen successful in the management of chronic pancreatitis. Its chief value is in (1) excluding the diagnosis of peptic ulcer and (2) demonstrating to the patient that there is little alternative to appropriate surgery. Surgical intervention should be timed so as to avoid habitual use of narcotics as well as the problem of severe undernutrition. Pain pathways seem ultimately to become so well established (as one sometimes sees in causalgia or other types of chronic pain) that regardless of treatment the pain pattern continues. The latter may not necessarily be related to the duration of the disease but more perhaps to the severity of pain and the patient's reaction as determined by his personality. Successful treatment of the severely undernourished patient is not only more difficult but there is also an increased hazard associated with any operative procedure.

Selection of Surgical Treatment.—Those procedures designed to decrease pancreatic secretion, viz, vagotomy with partial gastrectomy or

gastroenterostomy, or to interrupt sensory pathways, e.g., splanchnicectomy with or without celiac ganglionectomy, have been relatively unsuccessful and there would seem to be no indications for either of these procedures at the present time. Sphincterotomy as a routine method of management almost falls into the same category. It may be indicated, however, in two circumstances: (1) in conjunction with cholelithiasis or choledocholithiasis in an effort to preclude pancreatic duct reflux as well as assure adequate drainage of the common duct and (2) in those infrequent situations in which there appears to be obstruction or stenosis at the terminal portion of the duct of Wirsung as determined by retrograde or caudal pancreatography.[5] In general, however, with these exceptions, sphincterotomy as a definitive procedure for chronic pancreatitis has been disappointing. A single point of obstruction, in general, has been rare and multiple points of obstruction almost always have been encountered when a pancreatogram has been carried out. The objection to sphincterotomy is not that it fails to ablate the sphincter, since reflux can be demonstrated after adequate sectioning, but that ampullary obstruction is not a predominant etiological factor. In pancreatitis secondary to Vaterian stenosis, the lesions usually are well circumscribed (pericanalicular sclerosis predominating in the region of the head of the pancreas and diminishing peripherally).[3] This type provides the only indication for sphincterotomy. Sphincterotomy obviously is of little value when the pancreatic duct obstruction is at 2 to 3 cm. from the ampulla, as is frequently the situation.

Selection of the appropriate operative procedures is based upon identifying pathologic changes in the pancreas at the time of exploration. In general, following celiotomy, the pancreas is examined by direct inspection and palpation, with an attempt to identify any localization of the disease as well as its extent. The pancreas may exhibit a remarkable recovery from previous acute inflammation and fat necrosis. Particularly is this true in that form of pancreatitis associated with biliary tract abnormalities and in early diffuse forms of the disease. In some circumstances, biopsy and a frozen section examination of suspicious areas of fat necrosis may be helpful. In cases of fibrocalcific pancreatitis, the main problem is to determine the extent of the disease. There obviously may be involvement of the entire pancreas, which also may be seen with obstruction in the head due to neoplasm, or the disease may be confined to the body or the tail with an inflammatory mass in the lesser sac. Such careful examination of the pancreas should determine not only the extent and type of involvement but also be very helpful in determining the site of any possible pancreatic duct obstruction.

Having evidence of pancreatitis as well as the extent of the disease, the status of the biliary tract next should be appraised. In those individuals with known cholelithiasis or choledocholithiasis, correction of these lesions can be carried out directly. In the absence of any gross abnormalities of the biliary tree and with a suggestive clinical history its normality must be assured by aspiration of bile from the gallbladder and examining the sediment. Following careful evaluation of the sediment a cholangiogram is done. With injection under slightly increased pressure, a common channel with reflux into the pancreatic duct may be identified. Based upon these over-all findings and in conjunction with careful palpation of the head of the pancreas by mobilization of the first and second portions of the duodenum, appropriate biliary tract surgery can be carried out. The presence of common duct stones accompanying pancreatitis should be considered *prima facie* evidence of underlying partial common duct obstruction. Mere removal of the common duct stone is inadequate treatment. Adequate drainage of the common duct should be insured by choledochoduodenostomy or ablation of the ampullary sphincter.

In the absence of biliary tract disease, the extent of pancreatic disease must be carefully defined, viz, (1) confined to the head with a relatively normal body and tail, (2) confined to the tail or body or both, with a relatively normal head or (3) the entire pancreas is involved. Finally, the status of the pancreatic duct needs to be defined by a pancreatogram in each situation. The latter can best be done by (1) direct puncture of a palpably dilated pancreatic duct or (2) severance of the pancreatic tail and insertion of a polyethylene catheter into the pancreatic duct. There has been no morbidity nor mortality from an exacerbation of pancreatitis with this latter procedure, as is sometimes seen with retrograde injection by way of the ampulla of Vater.

Having established the extent of the disease, the normality of the biliary tree, and the characteristics of the main pancreatic duct, the appropriate surgical procedure may now be selected.

1. Disease confined to the head of the pancreas: pancreaticoduodenal resection with pancreaticojejunal anastomosis. In addition to re-

moving the primary lesion as well as any associated major duct obstruction, this procedure has the advantage of removing any underlying carcinoma. In poor risk patients with an associated dilated pancreatic duct, a lateral pancreaticojejunostomy may be performed as an alternative.

2. Disease confined to body or tail of pancreas: resection of body and tail of pancreas. It is essential to outline the remaining proximal pancreatic duct since, when normal, the severed pancreas may be closed. When the duct is somewhat dilated or otherwise abnormal, suggestive of early disease in the proximal pancreas, there may be an added advantage in carrying out pancreaticojejunostomy. It is surprising, however, how frequently the proximal duct is normal on pancreatography when the inflammatory reaction is grossly confined to the body and tail.

3. Diffuse disease with or without pancreaticolithiasis and with or without pancreatic duct dilatation: In general, diffuse disease without duct dilatation is unlikely to be associated with pancreatic calculi. Similarly, pancreatic calculi usually are associated with dilatation of the pancreatic duct and usually there are several areas of stenosis. Rarely is one stenotic segment encountered. With diffuse disease and in the absence of duct dilatation subtotal pancreatectomy is advised. Resection of the tail and body of the pancreas has been carried to the point just beyond the superior mesenteric vein. This represents approximately 75 to 80 per cent of the pancreas and is somewhat less than that carried out by Fry and Childs.[6] It may be that a more extensive resection is advisable but at the present time it has not been possible to readily identify which patients should have this more extensive procedure as an initial operation. With diffuse disease and a dilated pancreatic duct, pancreaticojejunostomy is in order—either by technique of Puestow or a modified Du Val procedure. If such a procedure fails to give adequate relief, 95 per cent distal pancreatectomy may be accomplished at the second operation.

Discussion

It must be recognized that with the exception of those procedures designed to correct biliary tract disease, these operations must be regarded as palliative—primarily for relief of pain since rarely do they correct the underlying disease mechanisms and rarely do they prevent continued progress of the disease. Furthermore, best results are achieved in association with a cooperative and understanding patient who abstains from alcohol and other drugs.

Utilizing the above approach in a series of 23 cases, there were no operative deaths and no instances of immediate postoperative pancreatitis. The best results were obtained in the cases of those patients with associated biliary tract disease, viz, six of seven. The one failure was in the case of a patient who died of biliary cirrhosis two and one-half years after his surgical treatment. Patients without biliary tract disease have good or excellent results much less consistently. Eight patients underwent some type of pancreaticoenterostomy, either with or without pancreatic resection (pancreaticoduodenectomies 3, pancreaticogastrostomies 2, pancreaticojejunostomies 3). Although the immediate results in terms of relief of pain and prevention of recurrent pancreatitis were good, the late results in terms of morbidity were very poor. Three of these individuals expired due to necrotizing pancreatitis at from 2 months to 22 months after surgery. This was despite the fact that they were relatively free of recurrent pain. Perhaps such a complication may be an indication for avoidance of pancreatic duct anastomosis and the more liberal use of sub-total pancreatectomy without pancreaticoenterostomy. In addition, two more of this group of patients expired approximately three months post-operatively, one from *Pseudomonas aeruginosa* bacteremia and one without medical attention. In patients undergoing partial pancreatectomy and in whom the remaining proximal pancreatic duct was not dilated, the results were much better with six of eight patients having from good to excellent results. The remaining two patients had intermittent discomfort but were improved. Thus, those individuals with pancreatic disease, either localized or diffuse, and with a normal pancreatogram had a good response to either partial or near total pancreatectomy. This group is particularly intriguing since for the most part it is composed of those patients in whom etiological factors could not be identified.

Patients with major pancreatic duct obstruction—frequently associated with pancreaticolithiasis and alcoholism—required some type of pancreaticoenterostomy with or without resection and had the greatest morbidity. This was not in terms of operative mortality, failure to relieve pain, or aggravation of existing pancreatic insufficiency. Although the number of patients is small, the mortality due to necrotizing pancreatitis following recovery from the initial operative procedure has been surprisingly high. Such a finding raises the question of whether these patients might be more safely treated by near total pancreatectomy. In many of these individuals there is already considerable destruction of pancreatic parenchyma. Little further loss of pancreatic exocrine function would

result from such a procedure. Warren has also reported a high long-term mortality in patients undergoing pancreaticoduodenal resection for pancreatitis. Most of the deaths, however, have been attributed to chronic alcoholism.[7] An operative mortality rate of approximately 10 per cent has been observed by Priestley, et al, in conjunction with surgical drainage of the pancreas.[8] On the other hand, Puestow lists 75 per cent of the results being satisfactory with a side-to-side pancreaticoenterostomy.[9] He does not mention long-term morbidity nor mortality.

In summary, the surgical management of chronic pancreatitis based upon pathologic findings has been outlined. Patients with associated biliary tract disease obtained the most satisfactory results. Pancreatic duct drainage procedures were utilized where obstruction and dilatation of the duct could be demonstrated. There was an unusually high morbidity and long-term mortality rate in this group of patients. Where no obstruction of the major pancreatic ducts was demonstrated, partial to subtotal pancreatectomy was employed with considerable success.

References

1. Ranninger, K. & Saldino: Arteriographic Diagnosis of Pancreatic Lesions, Radiol. 86:470, 1966.
2. Howard, J. M. & Jordan, G. L.: Surgical Diseases of the Pancreas, Philadelphia, J. B. Lippincott Company, 1960.
3. Sarles, H., Sarles, J.-C., Camatte, R. Muratore, R., Gaini, M., Guien, C. Pastor, J. & Le Roy, F.: Observations on 205 Confirmed Cases of Acute Pancreatitis, Recurring Pancreatitis and Chronic Pancreatitis, Gut 6:545, 1965.
4. Birnstingl, M.: A Study of Pancreatography, Brit. J. Surg. 47:128, 1959.
5. Nardi, G. L. & Acosta, J. M.: Papillitis as a Cause of Pancreatitis and Abdominal Pain: Role of Evocative Test, Operative Pancreatography and Histologic Evaluation, Ann. Surg., 164:611, 1966.
6. Fry, W. J. & Child, C. G. III,: Ninety-Five Per Cent Distal Pancreatectomy for Chronic Pancreatitis, Ann. Surg. 162:543, 1965.
7. Warren, K. W. & Veidenheimer, M.: Pathological Considerations in the Choice of Operation for Chronic, Relapsing Pancreatitis, New England J. Med. 266:323, 1962.
8. Priestley, J. T., Re Mine, W. H., Barber, K. W., Jr. & Gambill, E. E.: Chronic Relapsing Pancreatitis: Treatment by Surgical Drainage of Pancreas, Tr. South. S. A.: 76:230, 1965.
9. Puestow, C. B.: Discussion of Paper by Fry and Child.[6]

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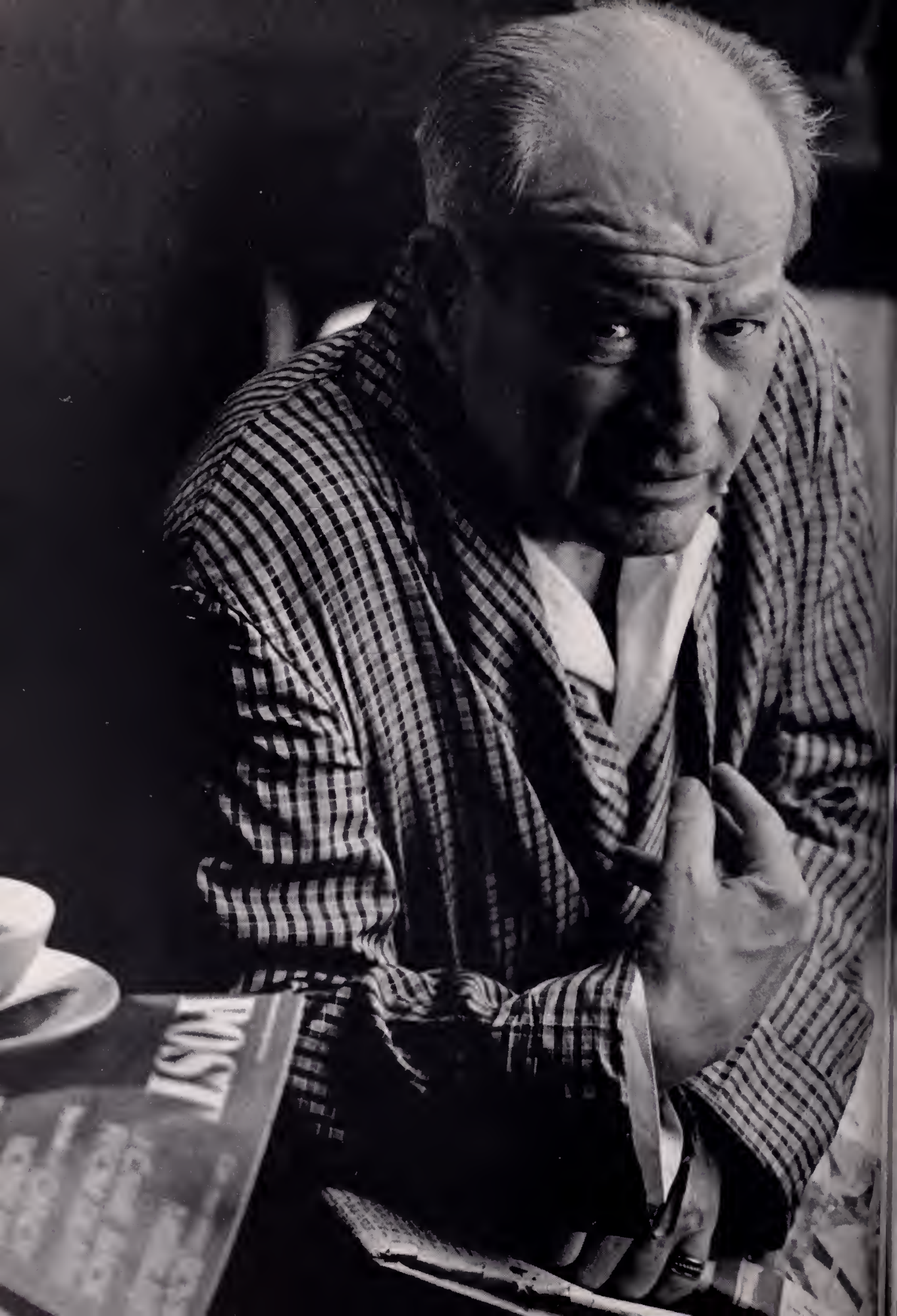
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SERVICE TO MEDICINE

Concurrent Ocular Abnormalities Found in 807 Patients With Minor Eye Disorders

Robert J. Herm, M. D.

When a patient presents himself with an ocular complaint such as foreign body sensation, discharge, or swelling of the eyelid, any physician may be tempted to treat the acute problem without looking further, especially if he is under pressure from a full waiting room or if he is seeing the patient in the emergency room of a hospital or industrial plant. Two or three minutes, however, devoted to more complete evaluation of both eyes may uncover a problem unconnected with, and of greater significance than, the one for which the patient seeks treatment. McPherson[1] recently reviewed the essentials of an ocular examination which can be performed adequately by one who is without specialized eye training.

The purpose of this paper is to report significant ocular abnormalities found coincidentally during brief but thorough examination of both eyes of 807 patients (age range 8 months to 93 years) whose presenting symptoms and signs were attributable to a minor ocular disorder of everyday occurrence.

Method

Data involved in this study were accumulated over a period of several years in the private office of an ophthalmologist. Certain routine procedures were carried out before any treatment was given (except that a drop of topical anesthetic was sometimes instilled to facilitate examination when the patient found it impossible to open his eyes): Determination of visual acuity at 20 feet with distance glasses if worn (a pinhole was used if patient's acuity with or without glasses was 20/40 or poorer); external examination of eyes and adnexa with magnifying loupe and flashlight; evaluation of pupillary size and response to light; evaluation of clarity of ocular media and examination of the central fundus by ophthalmoscope.

Results

Of 807 patients examined, 68 (8.4 per cent) demonstrated signs of concurrent ocular disease unrelated to the chief complaint.

Submitted to the Publication Committee, December 7, 1966.

The Author

- **Robert J. Herm, M. D., Assistant Professor of Surgery, Division of Ophthalmology, West Virginia University School of Medicine, Morgantown.**

Table 1

Diseases Which Prompted Patients to Seek Treatment Vs. Incidence of Concurrent Unrelated Abnormalities

Primary Diagnosis		Concurrent Abnormality		
Patients		*Patients*		*Per cent*
	Lid:			
168	Acute infection	22	22/168	13%
	Conjunctiva:			
187	Acute infection, foreign body	21	21/187	11%
	Cornea:			
452	Foreign body, abrasion, ultra-violet burn	25	25/452	6%
807 =	Total	Total = 68		

In only 50 per cent of cases was the concurrent abnormality apparent in the eye with the presenting problem.

Table 2

Laterality of Concurrent Disease

	Patients	*Per Cent*
Concurrent abnormality found in:		
Eye with presenting problem	20	29%
Fellow eye	33	48%
Both eyes	15	23%
Total =	68	100%

Concurrent abnormalities encountered more than once in this study, and the number of patients demonstrating them, were: Strabismus with amblyopia* (11); reduced vision due to previous trauma* (8); refractive amblyopia* (8); cataract* (6); strabismus without amblyopia (5); macular degeneration* (5); aphakia (3); previous dendritic keratitis (2); glaucoma, not known to patient (2); ptosis (2); and diabetic retinopathy (2). Concurrent abnormali-

*Best corrected visual acuity 20/40 or less.

ties demonstrated by only one patient in this study were: glaucoma, known to patient; hemangioma of the retina; occlusion of branch of central retinal vein; disciform degeneration of the macula; endothelial dystrophy; trichiasis of upper lids; exfoliation of the lens capsule; macular edema resulting from injury; scar of central chorioretinitis; eye signs of thyrotoxicosis; acute keratitis; congenital anomaly of lids and cornea; myopia, not known to patient; reduced vision from unknown cause.

Comment

Intra-ocular pressure was not measured because the writer believes it generally inadvisable to practice tonometry on an infected or injured eye.

The lower incidence of concurrent abnormalities among patients with corneal injuries may be attributable to the fact that this group was composed largely of industrial workers who had passed pre-employment examinations designed to screen out many ocular defects.

Twenty-five per cent of patients with a concurrent abnormality did not know it. Although 75 per cent of patients with a concurrent abnormality were aware of it, almost invariably the defect was not mentioned by the patient until it was discovered and he was questioned by the examiner.

In all instances the concurrent abnormality could have been discerned by a general practitioner employing the procedures previously listed, except for two which are detectable only by slit lamp examination (endothelial dystrophy and exfoliation of the lens capsule).

Summary and Conclusions

Of 807 patients who consulted an ophthalmologist for treatment of an acute ocular complaint of minor nature, 68 (8.4 per cent) were found to show an unrelated but concurrent ocular abnormality in the symptomatic eye, the fellow eye, or both. One-fourth of the patients with such accompanying abnormality were unaware of its presence. In several cases the concurrent abnormality indicated the presence either of significant systemic disease or disease constituting a threat to vision.

By devoting a few minutes to examination not only of the symptomatic eye but also of the fellow eye in patients seeking treatment for every day ocular complaints, any physician with a minimum of equipment can detect signs of concomitant disease which may require further investigation and treatment in order to preserve or promote good general health or eyesight.

References

1. McPherson, S. D., Jr.: Detection of Ocular Signs of Systemic Disease, West Virginia M. J. 62:109-110, 1966.

How To Go To Sleep

Let us all remember that we must not prescribe just the dosage that is given in a book; we must give enough to produce the effect we desire. Also we must not rigidly prescribe a dose every four hours; it is better to tell the nurse to give enough of the medicine to relieve pain, and when the pain returns to give another dose. I learned much pharmacology years ago when I watched a man quickly drink four martinis. He explained that he did not feel anything until he had four. And then I thought of the many times I had wondered why a man like that had to take three or four capsules of a barbiturate before he felt sleepy.—*Walter C. Alvarez, M. D., in Modern Medicine.*

Wounds, abscess, cellulitis

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Staph reliably controlled with specific therapy

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From time of birth, the child is exposed to a whole range of potential staph infections: wounds; secondarily infected dermatoses; primary lesions, such as deep impetigo (ecthyma), boils and felons; and more serious conditions such as osteomyelitis, staph pneumonia and staph meningitis.

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Hardly a staph organism can resist the bactericidal action of Prostaphlin® (sodium oxacillin), as shown by a 34-month *in vitro* study. Of all staph isolates tested, 99.5% were sensitive to oxacillin.[1]

Clinically Proven

There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo,* therapy with oxacillin can be extended when necessary.

Outstanding Safety Record

Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Suspension and Injectable

Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—an oral solution for pediatric use, capsules, and multi-dose vials for injection.

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.* 4 or *q.* 6 *h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY 8:12.16**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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Special Article

Partnership in Action*

William H. Stewart, M. D.

I am most happy to be able to take part in the 100th Anniversary observance of your State Medical Association and to visit a part of the country for which I have a kind of personal affinity. Although my upbringing was largely in the flatlands of the midwest and south, I find I am a mountaineer at heart, and I spend whatever time I can—which isn't much, lately—at a cabin a few ranges southeastward from here in the Blue Ridge.

A hundred years is a long time in the life of any institution. For a medical society it spans a greater gap than any previous thousand years. In 1867 we had just emerged from a war in which consignment to a hospital was widely considered to be a death sentence. The West Virginia physicians who met to form the society were undoubtedly medical statesmen of their time. But as practitioners they—in common with their colleagues all over the world—had very little to offer most people but tea and sympathy.

Today, physicians have at their command a powerful arsenal of weapons to preserve health and fight disease. This century of progress has seen the disappearance from this country of smallpox, yellow fever and other killers; the virtual disappearance of diphtheria and polio; the arrival of drugs and surgical techniques to arrest and cure an enormous range of ailments.

These magnificent tools, this wealth of knowledge, constitute the first great difference between the 19th century and our own. There is a second—no less laden with significance for the next hundred years. This is the great leap upward in public expectation of health care. As we take justifiable pride in our growing capability, we are increasingly aware that we are not yet fulfilling it for all the people, all the time.

Millions of Americans are served by medical care unsurpassed anywhere, any time. Millions of others are not.

*Presented before the Founders Day Dinner held at the Fairmont Hotel in Fairmont on April 10, 1967, to commemorate the 100th Anniversary of the founding of the West Virginia State Medical Association.

The Author

- **William H. Stewart, M. D., Surgeon General, U. S. Public Health Service, Department of Health, Education and Welfare, Washington, D. C.**

In some geographical areas, in some social groups, at some economic levels, effective health service simply does not exist. Many of our people are barred from access to first-class care. Worse, they are denied the most basic, elementary, routine services in prevention, early detection, and early treatment of disease.

Shortages in Health Manpower Supply

Here in Appalachia, in urban slums, and elsewhere across the nation, there are grave deficiencies in the health service system. We have serious shortages in the health manpower supply at every level; we have too few hospital and nursing home beds, too few clinics and health centers, too little equipment. Worse, we are not making the most effective use of what we have.

The results of these deficiencies are plainly visible. The millions of our poor have higher birth rates, more illegitimate births, more pregnancies with little or no prenatal care, and infant mortality rates two or three times as high as those in more affluent circumstances. They have higher death rates for tuberculosis, cancer of the cervix, cardiovascular-renal disease, influenza, pneumonia, and home accidents. The care they receive, when they receive it at all, is often low-quality, fragmented, impersonal care—certainly no matter of pride for those of us in the medical and health professions.

How shall we restore that pride? How shall we respond to the challenge of providing top-quality health services for 200 million Americans?

The only possible answer, it seems to me, is to mobilize our full health resources—not as an army is mobilized, with orders passed down

through a chain of command, but in full and productive partnership among the many elements that comprise that resource. We share a common goal. We need to share our talents to reach it.

We, here in this room, represent most of the elements that must pull together if we are to pull it off. Many of you are practicing physicians—now as always the fundamental component of the health team. You individually, and your local, state and national organizations, bear a great share of the national responsibility for health. Also represented here are community hospitals, group practice organizations, members of professions allied to medicine. The world of medical education is represented—the component that generates the knowledge and prepares the manpower that will shape the future. The public health disciplines are present and accounted for. And so, too, are representatives of the public we serve, the consumers of health service whose needs are our unfinished business.

Joint Responsibility

Finally, there is the partner I represent—the federal health enterprise. We are farthest removed of all from the firing-line where individual and family health needs are fulfilled. But we can help, and I believe we are helping, to create resources and encourage new patterns of using those resources. We are not the camel with his nose in the tent. Nor are we Big Brother, ever-present and menacing. We are quite simply a member of an alliance for health.

As a matter of fact, the Federal government is a long-standing member of the American health alliance. Federal care for American soldiers pre-dates the Constitution. My own agency, the Public Health Service, had its beginnings in the administration of John Adams, arranging for the care of merchant seamen. Medical and hospital care for veterans was started at about the time your Society was founded, just after the Civil War, at the National Home for Disabled Volunteer Soldiers. Before the turn of the present century the Federal government was carrying out quarantine activities and working with the states to control epidemics and improve sanitary conditions. Federal involvement in medical research began when Dr. Joseph Kinyoun, who had just returned from study at the Pasteur Institute in Paris, set up a laboratory in a back room at the Public Health Service's hospital on Staten Island.

Federal Participation Since World War II

But the great change in Federal participation has come since World War II. The Hill-Burton Hospital Survey and Construction Act of 1946 initiated a program that has added more than 300,000 hospital beds to the nation's resources and brought hospital care within easy geographic reach of almost all Americans. The grant programs administered by the National Institutes of Health have built the nation's powerful capability in biomedical research and helped to produce the new knowledge that has revolutionized medical practice. Beginning in 1963, the Federal government has become a full-fledged partner in the development of health manpower through a series of laws providing for support of medical, dental, nursing and allied professional education.

Thus we are profoundly committed to building the essential resources for the health partnership – knowledge, manpower, and facilities. But we are committed in a very special and significant way. It is the way of a democratic society. It is the way of local initiative.

The building-stone of our research effort is the research project, developed by the individual scientist in his university or research institution, reviewed by non-Federal scientific peers. Every Hill-Burton project begins with a locally developed community proposal, reviewed by a State agency and often by an areawide or metropolitan agency as well. Every new medical school, dental school or school of nursing starts with an idea and a plan in the place where the school will be built.

Thus the Federal role in resource development is founded on stimulus, incentive, support. The initiative is where the needs are and where the action must be taken—in the local setting.

Effective Use of Health Resources

This same pattern is clearly manifest in the big new programs designed to encourage more effective use of our health resources. It is clear in the concept of regional medical programs, authorized by the Heart Disease, Cancer and Stroke Amendments of 1965, in which universities, medical societies, community hospitals and other resources are being supported, region by region, in efforts to speed the transfer of knowledge to the patient who needs it. It is clear in the Comprehensive Health Planning Amendments passed last year which underwrite the planning process at the State and local levels and which provide new flexibility in the use of Federal grant funds for health services.

This principle has also been clear, and in my judgment notably successful, in the first year of life of the Medicare program. Secretary Gardner of Health, Education and Welfare, discuss-

ing Medicare with Doctor Appel and other medical leaders, recognized both the complexity and the promise of this legislation in these words:

"I believe that the Federal Government and various sectors of the private world—whether they are corporations or universities or professions—can enter into fruitful collaboration. I am convinced this collaboration can take a form that guarantees the continued integrity of private groups, that preserves local initiative, and that maintains the pluralism and public-private balance that we all treasure. . . .

"I find the real challenge of this legislation the opportunity it presents to the health professions to strengthen and renew themselves and to bring about vast improvements in the quality of medical care. These are the implications I find most exciting."

Medicare

I believe we can say that we are well on the road toward fulfilling this opportunity. In terms of its professional health aspects alone, activities associated with Medicare have brought positive and visible benefit.

In your neighboring State of Kentucky, in Texas, and in many other places, Medicare has made it possible for rural communities to attract and retain physicians and others who were being drawn away by economic opportunity in the cities.

The Conditions of Participation have helped administrators of non-accredited hospitals to convince their boards and their communities to improve services. Particularly, the standards have improved the physical environment of these hospitals and have enabled them to implement previously nebulous policies and procedures.

The standards for home health agencies are stimulating and supporting the effective development of home care services; already three-fourths of the home health agencies offer physical therapists' services and all offer at least one service in addition to the visiting nurse. Sixty-five per cent of the 1,800 agencies offer three or more services.

Training courses stimulated by Medicare have produced a high net gain in manpower. In Georgia, Oregon, Texas and elsewhere, Medicare has brought nurses out of the kitchen, recapped them, and put them back in active service in hospitals, nursing homes and home health agencies. Training programs in New York and New Jersey are aimed both at developing new skills for practicing nurses, physical therapists, nutritionists, dietitians and other health disciplines —so that they may extend their skills by serving as consultants and supervisors—and also aimed at refresher courses to reactivate inactive professional personnel.

Perhaps Medicare's most important contribution to effective resource development rests with the utilization review requirement. This has provided communities with an opportunity to look at their hospitals or extended care facilities or home health services, and better evaluate their place in meeting over-all community needs.

As a result an increasing number of relatively small rural hospitals which have historically experienced a low patient census are converting some of these empty beds to extended care beds. Larger community hospitals are planning and constructing new units which will be used as extended care facilities. The public hospital system of one State is in the process of being reviewed and evaluated in the light of Medicare's provisions. We believe this will prove beneficial to the entire medical care system of that State.

Finally, but by no means least in significance, there has been a significant change in the way Negro Americans receive hospital care. In hundreds of hospitals in all parts of the Nation, but especially in the South, quality medical care is now being offered to every sick person, regardless of his race. Negroes are able to enter hospitals that were previously reserved for white patients only. Negro physicians are able to apply for hospital staff privileges with some assurance that their applications will be considered on their merits.

New Health Challenge

I am not suggesting that none of these things would have happened without the stimulus of Medicare. Obviously, many of them are carrying forward trends already underway in response to the new health challenge. Nor am I suggesting that we have pressed a magic button and ushered in a bright new era. There is no such button; progress is ever uneven, halting, sometimes frustratingly non-existent.

But I am suggesting that Medicare has acted as an important catalyst in strengthening the partnership upon which our future depends. It has forged new health alliances in communities and states, and between them and the Federal government. In many, many places, initial suspicion has given way to mutual confidence and respect. This is the road to success.

Here in Marion County, West Virginia, you share the great health challenge of the nation

—to make the best in health care readily accessible to all our people. You share some of the special problems of your Appalachian Region. The task you face is not an easy one.

But you also share in the national health resource, and you have some special resources of your own. You have an active and vigorous group of physicians. You have a strong Group Practice organization and a particularly effective home health service program underway. You are within ready reach of the resources of your State university and its medical school. These are considerable assets to project against a considerable challenge.

Moreover, you have a strong tradition here of citizen participation in health affairs. In many places we are just beginning to recognize that the people we serve must be full, and not silent, partners in planning our health endeavors. The more broadly we involve all the people in our thinking, the more deeply our services are woven into the fabric of the community.

It is a great pleasure for me to salute the 100th anniversary of your medical association. It is a still greater pleasure for me to look ahead with you to another century of progress. Its promise for human well-being is virtually unlimited. A productive partnership among all of us can fulfill that promise.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink or pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

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1. Hepner, R., et al.: Pediatrics 33:94, 1964. 2. Hepner, R., et al.: Pediatrics (to be published). 3. Hansen, A. E., et al.: Pediatrics 31:171, 1963. 4. Holman, R. T.: Fed. Proceed. 23:1062, 1964. 5. Holman, R. T., et al.: Amer. J. Clin. Nut. 14:83, 1964. 6. Young, R. J., and Garrett, R. L.: J. Nut. 81:321, 1963. 7. Hepner, R.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," a colloquium held under the auspices of The Pediatric Department, Western Reserve University School of Medicine, Cleveland, Ohio, Sept. 8, 1966. 8. Carson, M., and Hart, L.: ibid. 9. Nichols, M.: ibid.

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Special Article

The Brain Drain: Europe's Young Physicians Seek Opportunities in the United States

In the past eight years nearly 125,000 of Europe's best educated young people have in one way or another sought admittance into the United States. They are graduate physicians in search of high-quality advanced education and the right to work unfettered by red tape and restrictions. Not finding it in their homelands, they turned to the United States.

Actually only a fraction of the 15,000 to 20,000 hopeful young doctors seeking entry each year ever arrive here. Figures of the Association of American Medical Colleges show that of those who take the Educational Council for Foreign Medical Graduates examination, only about one-fifth are accepted.

Still, that means that about 4,000 are arriving from Europe annually to work and study in medical schools and hospitals. And a large number of these are staying to practice medicine.

They are of all nationalities—German, French, Austrian, Swedish, and especially English. And their loss has helped create what for Europe is a major problem—the so-called "brain drain."

Medicine is not the only branch of science involved in the brain drain. Europe is also losing engineers, chemists, physicists—in fact scientists and technicians in all areas—to the United States. But the major exodus seems to be among the medically oriented.

The implications of the flight of its young scientifically educated has European leaders frankly worried. There is concern that the continent has become undeveloped scientifically and technologically in comparison with the United States. What's more, the gap is growing.

Even the Russians are fretful. For while they permit no emigration, they feel that because of the absence of scientific give-and-take in Europe generally, their own scientific programs are suffering.

Premier Kosygin of the Soviet Union made this clear during his visit to France. He proposed a "technological alliance" between Russia and Western Europe in order to end what he indicated was the dependence of Europe on advances made in the United States.

• **This article was prepared by the staff of the American Medical Association.**

Far more concerned with the outcome of the brain drain, however, is Great Britain. The emigration of its young physicians has threatened Britain's National Health Service (NHS) with collapse.

According to their own surveys, about one-third of Britain's medical graduates are leaving the country each year. What's more, the number of medical students going into training has been falling steadily.

British Health Service Dilemma

An eminent barrister, R. H. Davison, outlining the British health service dilemma, reported in the British Medical Journal: "Not only has the NHS provided outrageous terms and conditions of service, it has completely failed to inspire respect among the younger members of the profession who see through its Fabian humbug."

He noted that even the supply of doctors being imported from Pakistan and India to help fill the vacuum of British doctors was dwindling, and criticized the government suggestion "that the advent of the Common Market will permit us to import Italian doctors to run our Health Service."

"Clearly," Davison wrote, "fourteen years of socialism have made us completely shameless, for no one can believe these policies to be in the national interest."

That was five years ago. Since then the tempo of emigration from Britain has accelerated despite government efforts.

Why? The consensus of those British physicians arriving in this country seems to be that they have no wish to be "hand maidens of the government."

As one young resident said: "We're not exactly forced into servitude by the government,

but we're not exactly free to practice our profession either.

"At least in America there is still a choice. But what would happen if that choice were removed, as it has been in Europe? Where would American doctors emigrate to?"

Causes of Brain Drain

What has caused the drain of European brains? Is it money? Or is it something else?

Partly it is money. British interns say they work an average 100 hours a week for less than $200 a month. That figures out to about 45 cents an hour.

But the greater issue clearly is one of "scientific climate." Over-regulated conditions have served to stymie scientific inquiry; without scientific inquiry there is lack of stimulation, and without stimulation scientific advancement suffers. So goes the analysis of what's wrong with science in Europe.

This, of course, is an oversimplification. But the fact is that the young, scientifically-oriented have shown by their desire to vacate Europe that something about the scientific climate there is inadequate, if not stifling. And whatever it is, the medical school graduates of Europe have turned to the United States in order to get into the mainstream of medical science.

American medicine became a lure to European doctors following World War II when it became clear that the United States had emerged in the forefront of medicine. And despite the efforts by some to downgrade the image of American Medicine in order to foster a European system of medicine in this nation, the United States has continued to better its standing. If this were not so the "brains" of Europe wouldn't be seeking entry. For they crave scientific excellence along with freedom to practice their profession.

Medical Science in America

How good is medical science in America? A clear-cut answer is not easily obtained. Some critics, basing their argument wholly on one statistic or another, contend it is not very good. They maintain that because the infant mortality rates and the average life span in certain small European nations are somewhat better than our statistics these nations have better medicine.

Actually such statistics fail dismally as a yardstick for measuring the quality of a nation's medicine. Totally ignored in the conjectures based on these tables are such factors as genetic makeup, economic conditions, educational levels and other matters including abortion laws, all of which are reflected in statistics. For example, one of the best assurances of a ripe old age is to be born into a family with a history of longevity. This is a matter of genes, and has nothing to do with medicine. Medicine of course, plays a role in longevity, but it is only one factor of several. Similarly, one of the best buffers against infant mortality is a mother well educated in the facts of childbearing before she becomes pregnant.

The fact is, of course, medical and scientific quality cannot be based on one lone statistical table. Rather it must be judged on the sum total of numerous factors. Such a compilation clearly indicates that the young Europeans are probably right—the United States is the leader in medical science.

Nobel Prize Winners

In the 21 years since World War II, 23 Americans have been awarded the Nobel Prize in medicine and physiology. That's more than was won by physicians and scientists from all of the other countries of the world combined.

In the same period, well over half of all the major new drug discoveries were developed in this country. As a matter of fact, 80 per cent of the prescriptions written today could not have been written 10 years ago because the drugs didn't exist.

But medical progress cannot be measured only in the laboratory. It must also be measured in terms of people, disease, and facilities. Thus the fact that America was building 750 hospitals in the same time that England was building one also enters the picture.

So do such matters as the rate of death from various diseases. The death rate from cancer in America, for example, is well below the rate of Western Europe. And since cancer is treatable to some extent, our lower death rate could be interpreted as better medical treatment. The same holds true for other treatable diseases, including tuberculosis, pneumonia, strokes and influenza. All of these kill fewer people here, per capita, than in Western Europe.

What it all adds up to is this: Four and a half million Americans alive today would be dead if medicine were practiced with the same amount of knowledge and the same tools as it was just 25 years ago. In that time span—in the past 25 years—medicine has learned more than it learned in the previous 50 centuries.

No one can assign a nationality to such knowledge. It is world wide. But when it comes to teaching and applying that knowledge, the rest of the medical world looks to the United States for leadership.

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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: 600 mg. daily in divided doses for 2 to 3 days; 300 mg. daily thereafter. Usual duration of therapy: 2 to 7 days.

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The Arthritis Foundation looks forward to rapid growth with increasing opportunity for physicians to participate in the arthritis movement. For further information about The Arthritis Foundation and its programs write to the Foundation chapter in your community or to the Medical Department, Box 2525, New York, N.Y. 10001.

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From

The Woman's Auxiliary

to the

West Virginia State Medical Association

The Auxiliary members are happy to participate in the celebration of "100 Years of Progress in Medicine Under Freedom" in West Virginia. We, as partners with doctors in medicine, wish to declare our Convention as a Doctor's Day Birthday Party. Our wishes are manifold. God bless each of you—and to you we give our love and appreciation for your dedication to duty.

Dear Doctor:

I hope that during the past year you have had time to learn and think about the work being done by Auxiliary members. We have many projects besides taking care of our doctor-husbands. We participate in many community and world health projects by giving programs on various health subjects, not only to our own groups, but to church, school and civic organizations.

Perhaps you have seen us knitting leper bandages—well, that is not being done as therapy for the doctor's wife, but to fill a vital need for dressings in leper colonies throughout the world. An outstanding project has been the raising of funds for the American Medical Association Education and Research Foundation.

We also have both State and County loan funds for those entering nursing and allied health education programs. We encourage students to enter medically related fields. We encourage students to remain or to return to our State to help care for the sick. We work toward a warm and personal relationship between doctors' families. We stand by to be of help to you in your County Societies and State Association.

We appreciate the help of your officers and those serving as Advisors to the Auxiliary.

Sincerely,

Evanelle Myers

Mrs. Hu C. Myers,
President of the Auxiliary

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

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EDITORIALS

WHENCE THE HEALTH SERVICES

Elsewhere in this issue of *The Journal* is published the address given by William H. Stewart, M. D., Surgeon General of the United States Public Health Service, on April 10, 1967, at a meeting in Fairmont celebrating the founding 100 years ago of the West Virginia Medical Society which later became the West Virginia State Medical Association.

The theme of the address was "Partnership in Action," and the speaker repeatedly stressed in various ways the dictum of "fruitful collaboration" between government, medical organizations, medical and health personnel and the people whom they serve and treat.

We doctors, dedicated to providing the best care for our patients, as we have known that care, have long resisted the encroachment of governmental control in our doctor-patient relationships. This resistance has repeatedly served as a beneficial brake upon legislative and bureaucratic mavericks who would have thrown the health services and personnel into complete socialization. The restraint and advice of doctors and medical organizations has undoubtedly steadied the ship of progress as she sailed toward a more productive and promising land of health care.

Legislative provisions, vast new areas of knowledge in the health fields, and new surgical techniques now make it imperative that all affected parties confer, cooperate and respect each other if the greatest good health-wise is to be accomplished.

We in the West Virginia State Medical Association are embarking upon a second century of organized activity. We will, and should, resist changes which we deem detrimental to our patient's welfare. We aim to preserve the integrity of the private practice of medicine. On the other hand, we must not be unaware of the surge of social demands or the possibilities of benefit in heretofore untried trends. We practitioners should prove our high education by keeping an open mind to suggestions offering greater good for a greater number of people.

We should extend our thinking and proposals toward positive improvement rather than resistant objection to the new trends and demands of health education and legislation.

The Appalachian Regional Commission has spent great thought, time and effort planning

toward the establishment of more effective means for the prevention and treatment of illnesses in our area. This effort should be encouraged.

Our Council of the West Virginia State Medical Association, aided by the strenuous work of its personnel and other knowledgeable members of our Association, have carefully studied the plans and guidelines of the Appalachian Regional Commission. As expressed in the resolution published in the March 1967 issue of *The Journal*, the Council of the West Virginia State Medical Association approves of the development and operation of the proposed health service project, but rightfully insists that the health service centers shall not infringe upon the private practice of medicine and that their services shall be rendered at a cost commensurate with the patient's social and economic status.

The resolution also insists that there shall be adequate medical representation on all national, state, or local bodies having supervision or jurisdiction in the development of these health service projects.

It would seem that if government health agencies, departments of health-education and private practitioners of medicine can learn mutual respect for the knowledge and experience of each other and can agree upon the procedures for the future task aimed at better health for all people, the outcome must result in an accomplishment beyond all belief.

If we in the health field can obtain such a result by our mutual cooperation, perhaps we may set a pattern for world-wide mutual effort even resulting eventually in world peace.

THE CHALLENGE OF MEDICINE TODAY

Never since the days of Hammurabi have the study and practice of medicine offered such a challenge to a young person as they do today. The requirements for entrance to a medical school are high. After admission the studies are arduous, the years spent in training are long, the cost is increasingly great, and the sacrifices which the student must make of time, money, freedom, recreation and family life are appalling.

To accept this challenge today a student must have great courage of his convictions and a steadfast desire to learn the makeup and functions of the human body. He must have a sincere wish to help, cure, and repair those bodies imperfect by inheritance or broken by disease, accident, war, or the forces of nature; and in addition he must have a spirit combining strength, kindness, comprehension and compassion.

Once he is in practice the doctor must have the stamina to carry on a noble profession battling the problems of treating vicious diseases and injuries, many with no known cure, as well as standing up against the heat from virtual animosity of some persons and organizations, the threat of socialization and government control, and the constriction of his professional freedom by third parties, bureaus, and even hospital organizations. He must be prepared to withstand harassment from law suits by grasping individuals and their attorneys, often resulting in charges of malpractice or assault with the threat of the loss of standing in his profession and in his community as well as possible bankruptcy and pauperism, if a so-called jury of his peers sees fit to favor the plaintiff.

Selective professional taxation, probing by the internal revenue sleuths, and, at times, the jealousy and vituperation, even of his colleagues, may turn his nights from periods of rest into sieges of nightmares.

We live in an age of such struggle and rapid expansion of knowledge that the acquisition of the necessary information to become a doctor of medicine and pass the licensing and qualifying boards *in itself* sets the physician apart from other less able persons.

Why, then, in the face of an expanding knowledge, a markedly widened field of prevention, treatment and cures, and the continued struggle for professional improvement has the doctor come to be singled out for special torment? Is it jealousy? Perhaps. Is it a carefully planned bureaucratic and political campaign aimed at the subjugation of the profession? So it appears at times. Is it that in their justifiable pride in accomplishment some doctors have lost humility and the common touch? Let us hope not.

Have the leaders in the profession been so absorbed with organizational problems that human relationships have become subjugated to make way for financial and group welfare or randomizing research? Perhaps.

However depressing all of these factors may be today there are still young persons willing to accept the challenge and the sacrifice required to follow in our footsteps and carry the torch to a higher plateau on the mountain of understanding and knowledge. Let us back them up with every means at our commannd.

Though the way be hard, the personal satisfaction will, I promise them, be great, and may the Lord of all burdens and the guardian angel of the Great Physician go with them over the rough road.

How many of us think of the difference between a consultation and a referral? How many times has a patient been lost in the medical specialty whirlpool? Who is responsible to whom? Recently a patient was sent by a family physician to a dermatologist in another city for consultation. She was then sent to a surgeon for biopsy by the dermatologist and over a period of months a pathologist and radiologist had been consulted. When a definite diagnosis was not made her husband finally asked her own family physician "to find out what was going on."

PATIENT—QUO VADIS

Another example is the patient sent for surgical consultation: several weeks later the referring physician is asked by a family member why he didn't visit the patient in the hospital when she had surgery? The family takes a dim view of the physician when he replies, "I didn't know she was in the hospital."

It appears another word must be added to our usuable vocabulary—*Communication.* It is not only a problem of medical ethics, but of courtesy to the physician involved and the patient's welfare.

As we all know this not only happens to those of us in general practice as family physicians, but also to the internists and pediatricians.

Without being facetious when you consult: see, write and get out. When a patient is referred: see, treat and send back to referring physician when a definitive program of therapy is established.

There are complaints on both sides of the consultation and referral problem and both parties have erred referring and consulting.

When a patient is sent for consultation or referral a brief summary of illness should precede or accompany him. Included should be pertinent information or tests to help the consultant more quickly ascertain the problem without repetition. It is not only courteous, but most helpful to consultant and patient if the referring physician personally interviews the consultant. The hospital procedure of writing on the daily orders—"Consultation Dr. Doe" and leaving all arrangements to the nurse or hospital secretary, is a grave and expensive procedure for all parties, and the patient may suffer painfully and financially.

Prompt communication to the family or referring physician as to the opinion, treatment, etc., should be the rule of the consultant.

Communication—a note or letter—will solve most of the ill feelings that often occur with consultations and referrals, and remembering the difference will solve the rest.—*Guest editorial by Dr. L. Dale Simmons, Immediate Past President of the West Virginia Chapter, American Academy of General Practice.*

MEDICAL EDUCATION IN WEST VIRGINIA 1869-1967

Since the West Virginia State Medical Association is observing its Centennial it is of interest to summarize briefly the history of medical education in West Virginia University throughout the past 98 years. In 1869, two years after the University was founded, Hugh Workman Brock, M. D., a physician of Morgantown, was appointed lecturer in "Anatomy, Physiology, and Hygiene." Ever since that time there has been at least one man on the faculty of the University who had the M. D. degree.

Beginning with 1903 there were two men on the faculty with the M.D. degree who devoted all their time to teaching medical subjects. The number of full-time men who held the M.D. degree gradually increased, and in 1921 there were five. These men served in the following capacities: (1) administration, (2) professor of anatomy, (3) professor of pathology, (4) professor of pathology, and (5) professor of physiology. Besides these full-time men there were several others with the M.D. degree who served as part-time instructors and were responsible for teaching physical diagnosis, principles of medicine and principles of surgery. There were, of course, several others on the faculty who held the Ph.D. or the M.S. degree.

In 1935 when the School of Medicine was reorganized there were still five men on the faculty who had the M.D. degree and who devoted their full time to teaching medical subjects. There was but little change in the size of the faculty until the four-year curriculum was devloped in 1958-59. Since that time the faculty has grown rapidly, and presently there are, of course, a good number of full-time clinical men and women.

Although the role of the men who held the M.D. degree has been emphasized, it should not be construed to imply that the services of those who held either the Ph.D. or the M.S. degree are not fully appreciated. Many of these individuals had been trained in famous institutions and had brilliant teaching and research records. The School is under great obligation to their devoted services. This short essay, however, is concerned principally with those who hold the M.D. degree,

a number of whom were members of the State Medical Association, and, indeed, were quite active in the organization, several having served as President.

It is gratifying that throughout the past 98 years medical education had developed *pari passu* with the State Medical Association. It is to be hoped that both the State Medical Association and the School of Medicine of West Virginia University will not only continue to serve well the citizens of our State, but that their services may rise to even greater heights in the years which lie ahead.

TWO FORMER STATE PHYSICIANS HONORED

Two former West Virginia physicians were honored at the annual meeting of the Industrial Medical Association in New York City on April 12, 1967. The Meritorious Service Award was presented to Harold H. Golz, M. D., for distinguished and extraordinary service to the Association. Doctor Golz, who is Corporate Medical Director of the American Cyanimid Company, practiced internal medicine in Clarksburg for several years. Doctor Golz's many contributions to industrial hygiene and clinical toxicology were cited. He is the author of many articles on Industrial Toxicology.

Dr. Lemuel C. McGee of Wilmington, Delaware, presented the C. O. Sappington Memorial Lecture at the convention. The lecture is presented annually by a physician selected for his eminence in the field of occupational medicine, to honor the memory of one of industrial medicine's most illustrious pioneers. Doctor McGee is Medical Director of Hercules, Inc. From 1935-39 he was Chief of Internal Medicine at the Golden Clinic in Elkins.

The West Virginia State Medical Association is proud to report the distinguished achievements of its former members.

THE AMA CONVENTION—AND WHY WE GO

Buckminster Fuller, The American architect-engineer-philosopher-poet, has predicted that education will become the largest and most important of all industries. He bases this on a belief that knowledge is the one resource of man which not only cannot be depleted, but can, indeed, be consciously increased. In the advanced, automated world of the near future, he says, "leisure" time gained from the workaday world through automation may be spent in the classroom; in fact people may be paid to go to school.

Physicians have long understood the value of knowledge—of education. We are forever involved in the task of "keeping up"—without pay it may be noted.

There are few physicians who regard the task as onerous, however. "Keeping up" is part of being a physician; it is a privilege and a responsibility.

A number of reservoirs of medical information may be tapped by the physician. These include colleagues, medical journals, medical news publications, continuing education courses, medical meetings and conventions, drug detail men, and miscellaneous others.

Every year there is the "big show" where the physician can tap practically every reservoir: the Annual Convention of the American Medical Association.

At the 1966 Annual Convention about 600 scientific papers were presented, and nearly 300 scientific exhibits were on display as well as hundreds of industrial exhibits.

No other medical meeting in the world matches the range of subjects presented, from reviews of general medicine to experimental medicine and theraputics.

The 116th Annual Convention of the American Medical Association will be held in Atlantic City, June 18-22. Convention Hall and surrounding hotels will house the scientific program; the House of Delegates will meet at the Chalfonte-Haddon Hall Hotel.

Among special presentations planned are four general scientific sessions on backache, healing, patient care and sex.

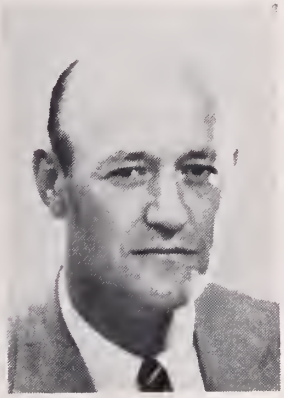
The 22 scientific sections will offer programs individually, and many will hold joint meetings on subjects of common interest. A full schedule of medical motion pictures is planned. At least five color telecasts will be broadcast, live from a Philadelphia hospital in cooperation with the University of Pennsylvania School of Medicine.

If knowledge is a resource as Buckminster Fuller says it is, the AMA Annual Convention is surely a mother lode.

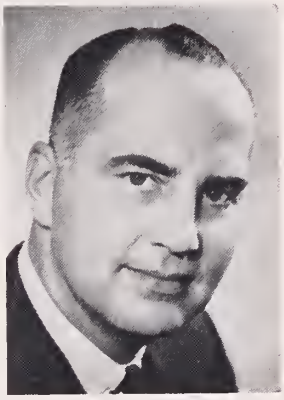
GENERAL NEWS

Drs. Lattimer and Ullery To Speak At Centennial Meeting

Two prominent physicians have accepted invitations to appear as guest speakers at the 100th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 24-26.



John K. Lattimer, M. D.



John C. Ullery, M. D.

Dr. Ray S. Greco of Weirton, Chairman of the Program Committee, announced that Dr. John K. Lattimer of New York City and Dr. John C. Ullery of Columbus, Ohio, have accepted invitations to present papers during the three-day meeting.

Doctor Lattimer, who is Professor and Chairman of the Department of Urology at the Columbia University College of Physicians and Surgeons, is a native of Mount Clemens, Michigan. He was graduated from Columbia College and received his M.D. degree in 1938 from the Columbia University College of Physicians and Surgeons.

He served an internship at Methodist-Episcopal Hospital in Brooklyn and served residencies in urology at Presbyterian Hospital, Babies Hospital and Vanderbilt Clinic in New York City.

He has been a member of the faculty at Columbia since 1940 and was named to his present position in 1955. From 1943 to 1946 he served with the Medical Corps of the U. S. Army and was stationed in England and Germany.

He is a Diplomate of the American Board of Urology and is currently serving as Chairman of the Committee for Pediatric Urology of the American Academy of Pediatrics. He also is a member of the American Medical Association, American College of Surgeons and American Urological Association.

John C. Ullery, M. D.

Dr. John C. Ullery, Professor and Chairman of the Department of Obstetrics and Gynecology at the Ohio State University College of Medicine, is a native of Bradford, Ohio. He was graduated from Ohio State University and received his M. D. degree in 1932 from Jefferson Medical College of Philadelphia. He served an internship at the Pennsylvania Hospital and was a Fellow in Urology at Miami Valley Hospital in Dayton, Ohio. He also served a residency at the Philadelphia Lying-in Hospital.

He served as a member of the faculty at Jefferson Medical College and the Graduate School of the University of Pennsylvania and was Chief of Service of the Department of Obstetrics and Gynecology at Philadelphia General Hospital from 1936 until 1954 when he was named to his present position at Ohio State.

He is Diplomate of the American Board of Obstetrics and Gynecology and is a Fellow of the American College of Surgeons and the American College of Obstetrics and Gynecology. He serves on the editorial board of several national medical journals and is the author of three textbooks and a large number of scientific papers which have appeared in medical journals.

Drs. Rouse and Gresham Honor Guests

It was announced previously that Dr. Milford O. Rouse of Dallas will speak at the first session of the House of Delegates on Wednesday afternoon, August 23, the day preceding the formal opening of the Centennial Meeting.

Doctor Rouse will be installed as President of the American Medical Association during the annual convention in Atlantic City later this month.

Another honor guest will be Dr. Perry E. Gresham, President of Bethany College. He will be the speaker at the Centennial Banquet which will be held on Friday night, August 25.

Other physicians and surgeons who will appear as speakers at the general scientific sessions are as follows:

Dr. Brian Blades, Lewis Saltz Professor of Surgery and Chairman, Department of Surgery, The George Washington University School of Medicine; and Dr.

Charles A. Doan, Dean Emeritus of the Ohio State University College of Medicine.

Business Sessions Scheduled

There will be two sessions of the House of Delegates during the meeting. The first session will be held on Wednesday afternoon, August 23, and the second session will be held on Saturday afternoon, August 26.

The Pre-Convention meeting of the Council will be held on Wednesday morning, August 23.

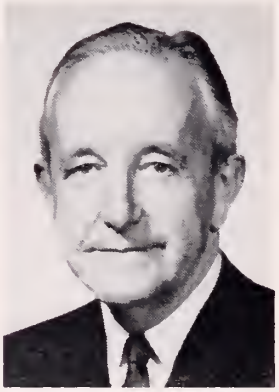
Features Planned for Centennial Meeting

As this issue of *The Journal* was placed on the press, arrangements have just about been completed for several outstanding attractions which have been planned especially for the Centennial Meeting. Complete details will be published in the July and August issues of *The Journal.*

Dr. Rouse To Be Installed As AMA President

The Annual Convention of the American Medical Association will be held in Atlantic City, New Jersey, June 18-22, with 35,000 persons, including 12,000 physicians, expected to be in attendance.

Milford O. Rouse, M. D.



Charles L. Hudson, M. D.

The convention will feature scientific sessions covering virtually every medical specialty. More than 400 scientific papers will be presented.

A highlight of the convention will be the installation of Dr. Milford O. Rouse of Dallas, Texas, as the AMA's 122nd President, to succeed Dr. Charles L. Hudson of Cleveland. The inaugural ceremony will be held on Tuesday, June 20, at Haddon Hall, beginning at 5 P. M.

House of Delegates Sessions

The AMA's policy-making House of Delegates will meet four times, with the first session scheduled for 10 A. M. on Sunday, June 18. The other sessions will be at 1:30 P. M. on Tuesday, June 20; at 9 A. M. on Wednesday, June 21; and at 9 A. M. on Thursday, June 22. The sessions will be conducted in the Pennsylvania Room of Haddon Hall and will be open to all registrants.

Drs. Frank J. Holroyd of Princeton and C. A. Hoffman of Huntington will represent the West Virginia State Medical Association as Delegates. Alternate Delegates are Drs. Thomas G. Reed of Charleston and D. E. Greeneltch of Wheeling.

Scientific Program

Topics for the general scientific sessions will include healing, sex, backache and patient care. The various specialty sections also will have scientific programs.

There will be a Multidiscipline Research Forum, at which 48 papers will be presented by researchers from a variety of medical specialties.

Five medical color television programs will originate from the Hospital of the University of Pennsylvania in Philadelphia, and will be seen in Convention Hall, Atlantic City.

West Virginians on Program

Several West Virginia physicians will participate in the scientific program.

Drs. Jorge Cueto, R. A. Currie and N. Tajen and Mr. Robert Mace, all of Morgantown, will present a paper at the Multidiscipline Research Forum on Thursday, June 22. Their topic is "Thoracic Duct Cannulation in Dogs With Surgically Created Portal Hypertension."

Dr. I. E. Buff of Charleston is a member of a Committee sponsoring an exhibit on Screening Examinations for Physicians. The objective is to interest physicians in their own health.

Dr. Harold L. Jellinek of Elkins will be among several Fellows of the American College of Cardiology available for consultation at the exhibit.

Dr. Allen E. Yeakel of the Division of Anesthesiology of the West Virginia University School of Medicine will sponsor an exhibit for the Section on Anesthesiology. The title of Doctor Yeakel's exhibit is "An Anesthesia Literature Abstracting and Retrieval Method—ALARM."

Dr. Edmund B. Flink, Chairman of the Department of Medicine at the WVU School of Medicine, will be the Representative to the Scientific Exhibit from the Section on Internal Medicine.

(The complete scientific program was published in the May 8 issue of *The Journal of the American Medical Association*).

Easter Seal Society Slates Annual Meeting

The Annual Convention of the National Society for Crippled Children and Adults (the Easter Seal Society) will be held at the Century Plaza Hotel in Los Angeles, November 16-19.

Hundreds of board members, volunteers and professional staff members from every state and Puerto Rico will gather to explore new developments in the rehabilitation of the crippled.

Additional information about the meeting may be obtained by writing to the National Society for Crippled Children and Adults, 2023 West Ogden Avenue, Chicago, Illinois 60612.

Dr. Carroll L. Witten (left) of Louisville, Kentucky, President of the American Academy of General Practice, was principal speaker at a banquet held during the West Virginia AAGP Chapter's meeting in Huntington, April 28-30. Talking with Doctor Witten are: Dr. Jack Leckie of Huntington (seated); Dr. L. Dale Simmons of Clarksburg (center), retiring President of the West Virginia Chapter; and Dr. J. H. Wolverton of Piedmont. In right photo, some officers and other members of the West Virginia Chapter are shown inspecting a scientific exhibit: They are (left to right): Dr. Del Roy Davis of Kingwood, President Elect; Dr. C. Carl Tully of South Charleston, Vice President; Dr. Martha Jane Coyner of Harrisville, President; Drs. Harold Van Hoose and Thomas P. Long, both of Man; and Dr. Virgil A. Deason of Logan.

Dr. Martha J. Coyner Installed As GP President

Dr. Martha Jane Coyner of Harrisville was installed as the first woman President of the West Virginia Chapter, American Academy of General Practice, during the organization's Scientific Assembly in Huntington, April 28-30.

Doctor Coyner is one of only a few women who have ever headed an AAGP chapter in this country. She succeeded Dr. L. Dale Simmons of Clarksburg.

Other new officers of the West Virginia Chapter include: Dr. Del Roy R. Davis of Kingwood, President Elect; Dr. C. Carl Tully of South Charleston, Vice President; Dr. James E. Spargo of Wheeling, Secretary; and Dr. Everett B. Wray of Beckley, Treasurer.

Members of the Board of Directors for the coming year are: Dr. John W. Whitlock of Beckley; Dr. Richard E. Flood of Weirton; Dr. Donald P. Brown of Kingwood; Dr. James H. Wolverton of Piedmont; Dr. Charles H. Barnett of Parkersburg; Dr. Joe N. Jarrett of Oak Hill; Dr. Richard C. Wallace of St. Albans; and Dr. Frank M. Booth of Huntington.

Drs. Seigle W. Parks and Carl B. Hall, both of Charleston, will represent the West Virginia Chapter as delegates to the AAGP later this year.

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, was appointed Program Chairman for the 1968 meeting, which will be held in Charleston next April 26-28.

Several eminent physicians and other scientists from West Virginia and other states presented papers at the scientific sessions.

The speaker for the annual banquet was Dr. Carroll L. Witten of Louisville, Kentucky, President of the American Academy of General Practice.

Doctor Coyner, the new West Virginia Chapter President, has been active in both the AAGP and the West Virginia State Medical Association for a number of years.

In the State Medical Association, she serves on the Committee on Medical Scholarships and is Chairman of the Rural Health Committee. Last year, she was appointed to the Council on Rural Health of the American Medical Association.

Doctor Coyner also is a member of the Advisory Board of the Sears-Roebuck Foundation.

A native of Buckhannon, Doctor Coyner holds B.S. degrees from West Virginia University in medical science and home economics. She received her M.D. degree in 1952 from the University of Pittsburgh, and served her internship at Ohio Valley General Hospital in Wheeling.

Nurse Anesthetists Complete Annual Meeting

Mrs. Irene Musgrove of Fairmont was installed as President of the West Virginia Association of Nurse Anesthetists at the organization's annual meeting in Fairmont in April.

Other new officers of the group include: Miss Jean Fabry of Moundsville, President Elect; Mrs. June Jones of Charleston, Vice President; and Mrs. Ocie Newlon of Bridgeport, Secretary-Treasurer.

Several physicians participated in presenting the scientific program. They included: Dr. John J. Schaefer of Charleston; Dr. Paul Dumke of Detroit, Michigan; Dr. Elizabeth Fox of Winston-Salem, North Carolina; Dr. Allen E. Yeakel of Morgantown; Dr. Franklin B. McKechnie of Winter Park, Florida; Dr. C. R. Stephen of Dallas, Texas; Dr. William A. Morrison of Morgantown; and Dr. William Jacobs of Clarksburg.

College of Physicians Lists Final PG Courses

Two programs in June will conclude the American College of Physicians' 1966-67 schedule of postgraduate medical courses.

The final courses, their dates and locations are as follows:

June 12-16—"Internal Medicine: Current Physiological Concepts in Diagnosis and Treatment," University of Cincinnati College of Medicine, Cincinnati.

June 19-21—"Clinical Applications—Recent Advances in Pharmacology," University of Iowa, Iowa City.

Fees include $60 for members of the ACP and $100 for nonmembers.

Additional information may be obtained by contacting Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Heart Programs Explained By Doctor Dyer

In a recent issue of the "State of the State's Health," State Health Director N. H. Dyer explained some of the programs of the Bureau of Heart Disease Control and said much could be done by health personnel to abate the spread of heart disease.

The health official discussed a program for rapid identification of streptococcal infections through which a physician anywhere in the State may submit a throat specimen to the State Hygienic Laboratory and receive a report by telephone within 48 hours.

"With specimen submissions from private physicians increasing at a rate of 41.7 per cent since last June, with more and more practicing physicians participating in this program, with more individual cases and epidemics being earlier identified and brought under control, the amount of "strep throat" in the state may be eventually reduced, and as a result, the incidence and prevalence of rheumatic fever and rheumatic heart diseases could be favorably affected," he said.

These three physicians of the 20th Century reflected on the past for a while during the West Virginia State Medical Association's Founders Day activities in Fairmont on April 10. Shown in the picture (left to right) are: Dr. G. Thomas Evans, Secretary of the Marion County Medical Society; Dr. David Bressler, President of the Society; and Dr. Ray S. Greco of Weirton, Chairman of the Program Committee of the State Medical Association. They made a pilgrimage to Rivesville, Marion County, where this monument in memory of the founders of the West Virginia State Medical Association is located. April 10 marked the 100th anniversary of the first meeting of the Association.

Doctor Dyer talked about the autoanalyzer equipment recently installed at the State Hygienic Laboratory in South Charleston. With this equipment, he said, a battery of at least 10 tests may be completed in the time required for a single evaluation—and from only one blood sample.

"This laboratory process adds an important new diagnostic and screening tool to the cardiovascular disease control arsenal. Through its widespread use, many early heart and other chronic disease conditions may be detected, then perhaps reversed or adequately managed, which certainly would translate into positive results where cardiovascular disease mortality rates are concerned," he said. Doctor Dyer emphasized that physicians and clinicians should be informed of this laboratory service and encouraged to participate in it.

Doctor Dyer mentioned that public health people can do much in helping hospitals develop an interest in coronary care units. "It has been well demonstrated that such units in hospitals save lives; yet most hospitals in West Virginia are without them," he said.

The relationship between cigarette smoking, heart disease, and lung cancer is now accepted without question by the majority of medical experts in this country, Doctor Dyer pointed out. However, the rate of cigarette addiction is not being affected by this finding, he said. "Sustaining community anti-cigarette smoking projects, spearheaded by local public health personnel, could affect a reduction in cigarette smoking which would in time doubtlessly affect heart disease and lung cancer death rates," he noted. Doctor Dyer added that assistance in the form of consultation and guidance for such projects is available upon request.

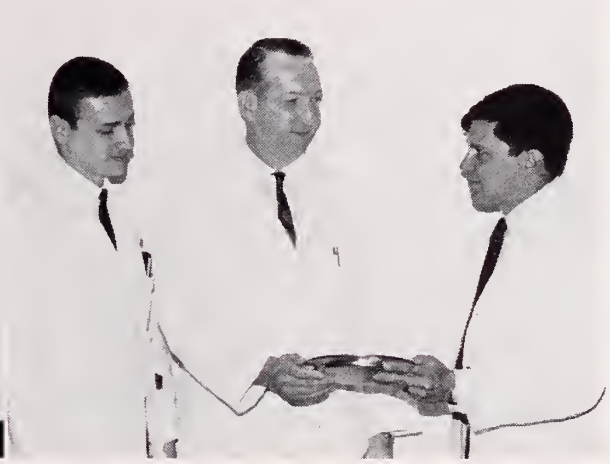
"Educating the public to an awareness of the correlation between cardiovascular diseases and such risk factors as obesity, high cholesterol foods, cigarette smoking, sedentary living habits, and hypertension is a considerable and long-term responsibility of health personnel," Doctor Dyer said. "Its rewards are also considerable in the way mortality rates may be eventually affected," he added.

To assist local heart disease health education efforts, there is material on almost every cardiovascular disease subject available (at no cost) from the Reference Library, Bureau of Heart Disease Control. Included are materials covering congenital heart defects, diet and heart disease, hypertension, rheumatic fever and rheumatic heart disease, smoking and health, cardiopulmonary resuscitation (for professional use), stroke, arteriosclerosis, heart diseases, and dental aspects of cardiovascular diseases. Most of these publications are suited for counselling of young mothers during well child conferences; for counselling adults and teenagers during public health nursing visits to families at home; for literature racks in health department rooms and clinics; for school health projects, and for educating special youth groups such as 4-H Clubs, Key Clubs, and Boy Scouts.

"The most immediate and direct way in which health personnel may do something about heart disease is for each to make an effort to know and to promote the use of what is now available to combat this number one health problem," Doctor Dyer said.

The health official encouraged physicians, clinicians, public health personnel, dentists, hospital officials, and others to contact the Bureau of Heart Disease Control for information concerning autoanalyzer laboratory procedure, rapid strep identification, or any of the heart disease program services.

"With proper utilization of the knowledge and methodology available to us," Doctor Dyer concluded, "something definitely can be done about heart diseases in West Virginia."



Two members of the faculty of the West Virginia University School of Medicine were honored by their students recently. In left photo, Dr. William W. Fleming (right), Chairman of the Department of Pharmacology, receives the MacLachlan Memorial Award for Excellence in Teaching in Basic Medical Science, from Roy Carter, President of the Second Year Class. This makes the second time Doctor Fleming has received the honor which is awarded by the second year class for "excellence as a teacher and interest in the scholastic progress of the entire class." In right photo, Dr. David Z. Morgan, Assistant Dean of the School of Medicine, receives an engraved plate from Gerald Ravitz, Editor of the School of Medicine yearbook "Pylon," as James Boso of Huntington, business manager of the yearbook, watches. The 1967 "Pylon" was dedicated to Doctor Morgan.

Dr. Morgan Is New President Of Oph.-Otol. Academy

Dr. William C. Morgan, Jr., of Charleston, took office as President of the West Virginia Academy of Ophthalmology and Otolaryngology during the organization's spring meeting, which was held at The Greenbrier in White Sulphur Springs, April 23-26.

Doctor Morgan succeeds Dr. Worthy W. McKinney of Beckley.

Dr. Arthur H. Keeney (center), Opthalmologist-in-Chief of the Wills Eye Hospital in Philadelphia, was one of the guest speakers at the spring meeting of the West Virginia Academy of Ophthalmology and Otolaryngology. He is shown here with Dr. J. Elliott Blaydes, Jr., of Bluefield (left) and Dr. Worthy W. McKinney of Beckley, retiring President of the Academy.

Other new officers of the Academy include:

Dr. R. Alan Fawcett of Wheeling, Vice President; Dr. J. Elliott Blaydes, Jr., of Bluefield, Secretary-Treasurer; and Drs. Edward Shupala of Parkersburg, Nime K. Joseph of Wheeling and Albert C. Esposito of Huntington, Directors.

Doctor Blaydes said this year's spring meeting was the most successful one the Academy had ever sponsored.

Guest speakers were: Drs. Wallace Rubin of New Orleans; Joseph A. C. Wadsworth of Durham, North Carolina; Howard P. House of Los Angeles; Alson E. Braley of Iowa City, Iowa; Arthur H. Keeney of Philadelphia; Sam H. Sanders of Memphis, Tennessee; Donald Shafer of New York City; and George Allen Sisson of Syracuse, New York.

AMPAC Workshop in Washington

The annual National Workshop of the American Medical Political Action Committee will be held in Washington, D. C., June 3-4.

Five members of the Board of Directors of the West Virginia Medical Political Action Committee (WESPAC) will attend the sessions.

They are: Dr. Frank J. Holroyd of Princeton and Mrs. Charles L. Goodhand of Parkersburg, Co-Chairmen of the Board; Mrs. Pat A. Tuckwiller of Charleston, Secretary-Treasurer; and Drs. Albert C. Esposito of Huntington and Richard E. Flood of Weirton.

Dr. Worthy W. McKinney of Beckley (third from left), retiring President of the West Virginia Academy of Ophthalmology and Otolaryngology, receives a plaque from Dr. J. Elliott Blaydes, Jr., of Bluefield, Secretary-Treasurer, in recognition of his contributions to the Academy during the past year. Pictured (left to right) are: Dr. James T. Spencer of Charleston; Doctor Blaydes; Doctor McKinney; Dr. William C. Morgan, Jr., of Charleston, the new President of the Academy; and Dr. Nime K. Joseph of Wheeling.

Shown above are four of the speakers who participated in the spring meeting of the West Virginia Academy of Ophthalmology and Otolaryngology. From left to right they are: Dr. Wallace Rubin of New Orleans, Louisiana; Dr. Joseph A. C. Wadsworth of Durham, North Carolina; Dr. Howard P. House of Los Angeles; and Dr. Alson E. Braley of Iowa City, Iowa.

Dr. D. Franklin Milam Presents Paper

Dr. D. Franklin Milam of Morgantown was among speakers at a Symposium on Trauma, which was held May 6 at the University of Virginia Hospital in Charlottesville.

Doctor Milam's topic was "Urological Complications of Pelvic Fractures."

He is Professor of Urology at the West Virginia University School of Medicine.

Medical Education of National Defense presented the program.

Woman's Auxiliary Conducts Board Meeting

Thirty members of the Woman's Auxiliary to the West Virginia State Medical Association attended the Spring Board Meeting and Workshop in Parkersburg, April 25-26.

Mrs. Donald R. Lantz, President of the Woman's Auxiliary to the Parkersburg Academy of Medicine, was Chairman for the meeting.

Mrs. Hu C. Myers of Philippi, President of the State Auxiliary, presided at the meeting.

Other officers who gave reports included: Mrs. Rupert W. Powell of Fairmont, President Elect; Mrs. Joe N. Jarrett of Oak Hill, Secretary; Mrs. William T. Lawson of Fairmont, Corresponding Secretary; and Mrs. J. Dennis Kugel of Charleston, Treasurer.

Brief reports also were presented by chairmen of the state committees and the presidents of the component auxiliaries.

Mrs. Pat A. Tuckwiller of Charleston and Mrs. C. R. Davisson of Weston announced plans for the State Auxiliary Convention, which will be held at The Greenbrier in White Sulphur Springs, August 24-26.

A social hour and dinner were conducted as a part of the meeting.

Guests at the meeting included Dr. Richard E. Flood of Weirton, President of the State Medical Association, and the following members of the Auxiliary's Advisory Board and their wives: Dr. Seigle W. Parks of Charleston; Dr. Hu C. Myers of Philippi; and Dr. George A. Curry of Morgantown.

Mercer Reservoir Is Named For Dr. Daniel Hale

A reservoir named in honor of Dr. Daniel Hale of Princeton will be dedicated in Mercer County on July 1 with U. S. Sen. Robert C. Byrd serving as principal speaker.

The facility has been named the Dr. Daniel Hale Reservoir to honor Doctor Hale for his key role in the development of the project. Doctor Hale, a member of the West Virginia State Medical Association, has been a leading figure in the development of the entire Brush Creek watershed program, which includes three impoundments.

Other notables expected to attend the July 1 ceremony include Gov. Hulett C. Smith, State Agriculture Commissioner Gus Douglas, and U. S. Rep. James Kee of Bluefield.

Medical Technologists Install Parkersburg Man

Mr. Lyle Dayhoff, a technologist at Camden-Clark Hospital in Parkersburg, was installed as President of the West Virginia Society of Medical Technologists at the group's annual meeting in Charleston in April.

He succeeds Mr. Dane Moore of Morgantown.

Mr. Robert Winemiller of Clarksburg was named President Elect; Margaret Houser of Huntington was elected Secretary and Alma Miles of Montgomery was named Treasurer.

The Society awarded its "Medical Technologist of the Year" plaque to Miss Thelma Wilson of Appalachian Regional Hospital in Beckley.

Mrs. Hu C. Myers of Philippi (center), President of the Woman's Auxiliary to the West Virginia State Medical Association, presided at the Auxiliary's Spring Board Meeting and Workshop, which was held in Parkersburg in April. Pictured are: Dr. Donald R. Lantz; Mrs. Lantz, President of the Woman's Auxiliary to the Parkersburg Academy of Medicine; Dr. Hu C. Myers of Philippi; Mrs. Myers; Dr. Richard E. Flood of Weirton, President of the State Medical Association; Mrs. Dwight P. Cruikshank; and Doctor Cruikshank, President of the Parkersburg Academy of Medicine.

AMA Auxiliary Convention In Atlantic City

Dr. Mary Calderone, noted proponent of sex education, will be one of the principal speakers at the 44th Annual Convention of the Woman's Auxiliary to the American Medical Association, which will be held in Atlantic City, June 18-22.

Mrs. Asher Yaguda

Mrs. Hu C. Myers

According to Mrs. Asher Yaguda of Newark, New Jersey, Auxiliary President, Doctor Calderone will speak on "Sex Education: Goals and Means" on Tuesday morning June 20.

Also speaking on Tuesday will be Dr. Charles L. Hudson of Cleveland, President of the AMA. Doctor Hudson will speak at a luncheon honoring Auxiliary past presidents and AMA officers and trustees.

Mrs. Yaguda and Mrs. Karl F. Ritter of Lima, Ohio, President Elect, will be honored at a reception on Sunday, June 18. Mrs. Ritter will take office on Wednesday, June 21.

Mrs. Hu C. Myers of Philippi, President of the Woman's Auxiliary to the West Virginia State Medical Association, will head the West Virginia delegation at the meeting.

Besides its business, the Auxiliary will sponsor a teen-age program for children of physicians and guests attending the AMA convention. A Sunday afternoon mixer and pool party are among the events planned.

Dr. C. A. Hoffman Is Re-Elected Blue Shield Secretary

Dr. C. A. Hoffman of Huntington, who recently was installed as President of the American Urological Association, has been re-elected Secretary of the National Association of Blue Shield Plans.

The announcement of Doctor Hoffman's re-election was made following the annual meeting of the Association's Board of Directors at Bal Harbour, Florida, April 15-17.

Doctor Hoffman is a Past President of the West Virginia State Medical Association and serves as a member of the House of Delegates of the American Medical Association.

New Association Members

Dr. M. Jamil Ahmed, Appalachian Regional Hospital, Beckley (Raleigh). Doctor Ahmed, a native of West Pakistan, was graduated from Gordon College, Pakistan, and received his M. D. degree in 1945 from the King Edward Medical College in West Pakistan. He interned at the Mayo Hospital in Lahore, West Pakistan, and served residencies at the University of Vermont, 1957-58, and Parkland Memorial Hospital, Dallas, Texas, 1958-61. His specialty is pathology.

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Dr. A. R. Bautista, Laird Memorial Hospital, Montgomery (Fayette). Doctor Bautista, a native of the Philippines, was graduated from the University of Santo Tomas and received his M.D. degree from the University of Santo Tomas in 1953. He interned at the SS Mary and Elizabeth Hospital, Louisville, Kentucky, and served residencies at St. Mary's Hospital in Cincinnati and the State TB Hospital in Louisville. His specialty is surgery.

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Dr. Castillo Campa, Southern West Virginia Clinic, Beckley (Raleigh). Doctor Campa, a native of Mexico, was graduated from the University of Mexico in 1943. He received his M. D. degree from the University of Mexico Medical School in 1951. He interned at St. Joseph Hospital in Lexington, Kentucky, 1955-56, and served a residency in orthopedics, 1956-60. He served with the Mexican Army and his specialty is orthopedic surgery.

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Dr. Robert J. Gardner, Fairmont Clinic, Fairmont (Marion). Doctor Gardner, a native of Bareington, Illinois, was graduated from State University of Washington in 1947 and received his M. D. degree from the Northwestern University Medical School in 1951. He interned at Cook County Hospital in Chicago, Illinois, 1951-52, and served a residency at the Northwestern University Surgical Training Program, 1958-62. He served with the United States Naval Reserve from 1943-46 and his specialty is general surgery.

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Dr. Ezequiel E. Gimenez, 1026 Quarrier Street, Charleston (Kanawha). Doctor Gimenez, a native of Asuncion, Paraguay, was graduated from the University of Paraguay and received his M. D. degree in 1947 from the University of Paraguay. He interned at Mobile County Hospital, 1949-50, and served a residency at the Veterans Administration Hospital, Gulf Port, Mississippi, 1961-64. He did postgraduate work at the Louisiana State University Medical School. His specialty is psychiatry.

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Dr. Robert W. Hansen, Stevens Clinic Hospital, Welch (McDowell). Doctor Hansen, a native of Marenisco, Michigan, was graduated from the University of Michigan and received his M. D. degree from the University of Illinois College of Medicine in 1949. He interned at Butterworth Hospital in Grand Rapids, Michigan, 1949-50, and served residencies at St. Marys Hospital, Grand Rapids, Michigan, and Henry Ford Hospital in Detroit. He served with the United States Army Reserve, 1942-45 and from 1950-52. His specialty is general surgery.

Dr. Harry F. Cooper Heads State ACS Chapter

Dr. Harry F. Cooper of Beckley recently was elected President of the West Virginia Chapter, American College of Surgeons.

Doctor Cooper succeeds Dr. Theodore P. Mantz of Charleston. Officers were elected during the Chapter's spring meeting, which was held at The Grenbrier in White Sulphur Springs, April 13-15.

Other new officers for the coming year include: Dr. Richard A. Currie of Morgantown, Vice President; and Dr. John W. Trenton of Kingwood, Secretary-Treasurer.

Councillors include Doctor Mantz and Drs. E. F. Heiskell, Jr. and Hu C. Myers of Philippi.

About 50 members of the West Virginia Chapter and other physicians attended the meeting.

The Chapter will conduct its fall meeting in Morgantown, October 27-28, and its spring session at The Greenbrier next May 2-4.

Re-Registration Deadline June 30

Application forms for re-registration to practice medicine were mailed recently by the Medical Licensing Board to all physicians currently licensed to practice in the State of West Virginia.

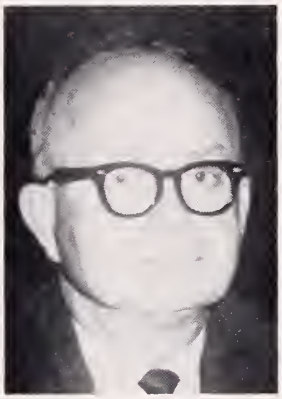
The biennial fee for the re-registration of physicians is $5. The deadline for payment of the re-registration fee is June 30.

Physicians who have not received the application form should contact the Medical Licensing Board of West Virginia, State Office Building, 1800 Washington Street, East, Charleston, W. Va. 25305.

Dr. Joseph A. Smith of Dunbar (left), President of the Kanawha Medical Society, presents a check for $600 to Marshall Buckalew, President of Morris Harvey College in Charleston, as Mr. Frank LePage, Director of the College's School of Nursing looks on. The check represents a year's scholarship, which will be awarded to some deserving student. The Society also awarded a scholarship to the Charleston General Hospital School of Nursing.

Public Health Association Honors Dr. Daniel Hale

Dr. Daniel Hale of Princeton was honored for his outstanding contributions to the field of public health at the 43rd annual State Health Conference sponsored by the West Virginia Public Health Association in Charleston, May 10-12.



Daniel Hale, M. D.

Mrs. Marian B. Cornell

Also honored was Mrs. Marian B. Cornell, former Director of the State Health Department's Bureau of Nutrition.

State Health Director N. H. Dyer presented the Merit Award to Mrs. Cornell for her professional public health work, and the Citizen Award to Doctor Hale for his contributions as a citizen to West Virginia's public health program.

A native of Onoville, New York, Mrs. Cornell was Director of the Bureau of Nutrition from 1956 until this year. She received B.S. and M.S. degrees from West Virginia University.

Doctor Hale was born in Princeton and received his M.D. degree in 1937 from Northwestern University Medical School. He is widely known for his activities in the field of conservation.

Doctor Hale has served as Chairman of the Mercer County Board of Health, Chairman of the Steering Committee for the Southern West Virginia Regional Appalachian Programs and was elected "Outstanding Citizen" by the Princeton Junior Chamber of Commerce two years ago. In 1966, he received the Governor's Award as State Conservationist of the Year.

Hospitals Get Big Slice Of Health Dollar

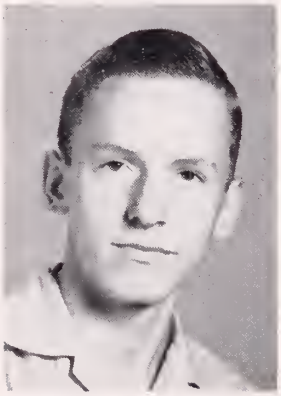
Americans spent about $28 billion on health care in 1965, an increase of about 9.5 per cent over the 1964 figure, according to the U. S. Department of Commerce statistics published recently in *The AMA News*.

The health care dollar, according to the statistics, was spent this way:

Hospitals, 30 cents; physicians, 27.7 cents; drugs, 16.4 cents; dentists, 9.6 cents; health insurance, 7 cents; appliances, 4.4 cents; and miscellaneous expenses, 4.9 cents.

Two 1967 Scholarship Recipients Selected By Committee

Two young men from large rural West Virginia families have been awarded four-year scholarships to the West Virginia University School of Medicine by the West Virginia State Medical Association.



Dewey F. Bensenhaver

Deleno H. Webb, III

Dr. J. P. McMullen of Wellsburg, Chairman of the Association's Committee on Medical Scholarships, said this year's recipients of the annual scholarships are Dewey F. Bensenhaver of Rig, Hardy County, and Deleno H. Webb, III, a native of St. Marys. The recipients will receive $1,000 apiece for each of their four years at the School of Medicine for a total of $4,000 each.

Both young men have been accepted by the School of Medicine as first-year medical students starting next fall.

Bensenhaver, 20, was born at Rig, the eighth of 10 children of Mr. and Mrs. Charles B. Bensenhaver. His father operates a cattle and poultry farm in Hardy County.

A graduate of Moorefield High School in the class of 1964, young Bensenhaver is completing his pre-medical studies at West Virginia University.

Webb, 27, is one of seven children of Mr. and Mrs. Deleno H. Webb, Jr., of St. Marys. He is married and the father of two children. His wife, a registered nurse, is currently employed by the Veterans Administration Hospital in Huntington.

The family presently is residing in Chesapeake, Ohio, but will move to Morgantown in the near future.

Webb was graduated from St. Marys High School in 1957, served in the U.S. Marine Corps and is taking his pre-medical education at Marshall University. He is employed in the emergency room at St. Mary's Hospital in Huntington.

Bensenhaver and Webb are the fifteenth and sixteenth deserving students to be awarded scholarships since the Association began the program several years ago.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1967

June 15-16—Am. Rheumatism Assn., New York City.
June 15-17—Am. Col. of Chest Phys., Atlantic City.
June 16-17—Am. Geriatrics Soc., Atlantic City.
June 17—Acad. of TB Phys., Atlantic City.
June 17-18—Am. Diabetes Assn., Atlantic City.
June 18-22—AMA Annual Con., Atlantic City.
June 22—Annual Preston County Meeting, Kingwood.
June 26-29—Am. Orthopaedic Assn., Hot Springs, Va.

July 14-15—Rocky Mtn. Cancer Conf., Denver.
July 23-29—Sou. Seminar in Ob. & Gyn., Asheville, N. C.

Aug. 21-24—Am. Hosp. Assn., Chicago.
Aug. 24-26—100th Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.
Aug. 27-Sept. 1—Am. Acad. of Phys. Med. & Rehab., Miami Beach.

Sept. 7-9—Am. Assn. of Ob. and Gyn., Hot Springs, Va.
Sept. 15-23—AAGP, Dallas.
Sept. 22-29—Col. of Am. Pathologists, Chicago.
Sept. 26-28—Ky. Medical, Louisville.
Sept. 27-30—Penn. Medical, Philadelphia.
Sept. 29-Oct. 1—W. Va. Heart Assn., Wheeling.
Sept. 29-Oct. 3—Am. Soc. of Anes., Las Vegas.

Oct. 2-6—ACS, Chicago.
Oct. 5-7—Assn. of Am. Phys. & Sur., Houston.
Oct. 19-21—Va. Medical, Alexandria.
Oct. 20-24—Am. Heart Assn., San Francisco.
Oct. 21-26—Am. Acad. of Ped., Washington.
Oct. 25-28—Cong. of Neurological Sur., San Francisco.
Oct. 29—Am. Assn. of Oph., Chicago.
Oct. 29-Nov. 3—Am. Acad. of Oph. and Otol., Chicago.

Nov. 13-16—Southern Medical, Miami Beach.
Nov. 16-19—Nat. Soc. for Crippled Children & Adults, Los Angeles.
Nov. 25-26—Am. Col. of Chest Phys., Houston, Texas.
Nov. 26-29—AMA Clinical Meeting, Houston, Texas.
Nov. 29-Dec. 3—Am. Med. Women's Assn., Atlanta.

Dec. 2-7—Am. Acad. of Dermatology, Chicago.
Dec. 4-6—Sou. Surgical Assn., Hot Springs, Va.

1968

Jan. 17-18—Am. Rheumatism Assn., Baltimore.
Jan. 20-25—Am. Acad. of Orthopaedic Surgeons, Chicago.
Jan. 29-31—Soc. of Thoracic Sur., New Orleans.

Feb. 3-7—Am. Acad. of Allergy, Boston.
Feb. 6-10—Am. Col. of Radiology, Chicago.
Feb. 28-March 3—Am. Col. of Cardiology, San Francisco.

March 18-20—Am. Acad. of Ped., Atlanta.
March 24-29—Am. Col. of Allergists, Denver.
March 29-31—Am. Soc. of Int. Med., Boston.

April 1-5—ACP, Boston.
April 16-19—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 17-19—Maryland Medical, Baltimore.
April 22-24—Am. Assn. for Thoracic Surg., Pittsburgh.
April 22-25—Am. Col. of Ob. & Gyn., Chicago.
April 25-26—Am. Hosp. Assn., Hollywood, Fla.

May 1-2—Am. Ped. Soc., Atlantic City.
May 12-17—Am. Psy. Assn., Boston.
May 13-16—Am. Urological Assn., Miami Beach.
May 23-25—Am. Gyn. Soc., Hot Springs, Va.

100TH ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 24 - 26, 1967

CENTENNIAL YEAR 1867-1967

WVU Medical Center
—News—

SIXTY-EIGHT young men and women have been admitted as first year students in the School of Medicine beginning next fall, according to Dr. Clark K. Sleeth, Dean of the School.

Previous entering classes have numbered 60 students, but Doctor Sleeth said the increase of eight was made possible chiefly by federal funds available under the Health Professions Education Assistance Act.

The 68 entering students were selected from among 286 applications. Of the entering class, 49 are residents of West Virginia. Fifteen of the 19 non-residents are from states in the immediate region.

As a group, the new class presented pre-medical grades averaging "B," and the Medical College Admission Test scores averaged in the 60th percentile nationally.

The new students from West Virginia communities are as follows:

Deborah A. Adkins, Barboursville; Hamil C. J. Kessel, Beckley; Nolan C. Parsons, Jr., Belmont; James K. Egnor II, Branchland; James H. Ashworth, Buckhannon; and Joel V. Allen, Francis D. Harris, Margaret E. Kern, and Timothy J. Looney, all of Charleston.

Pietro V. Caruso, Clarksburg; Richard W. McGan, Davy; Maxwell B. Snedegar, Elkins; Toby J. Billings, Fairview; James C. Durig, Glen Dale; Evelyn A. Hearl, Hemphill; William C. Dressler and Thomas E. McCay, both of Huntington; James W. Kessel, Logan; and John A. Francis, Lyburn.

John P. MacCallum, Madison; Mary J. Feist, McMechen; David C. Blass, Alfred E. Gibbons, Richard K. Herrick, Russel V. McDowell, and John T. Samsell, all of Morgantown; J. K. Lilly III, Oak Hill; and John D. Lyons and Janice E. Milligan, both of Parkersburg.

Lloyd M. Lamp, Point Pleasant; Emerson S. Mann, Princeton; Mary Belle Taylor, Quinwood; Dewey F. Bensenhaver, Rig; Michael R. Atherton, Shepherdstown; Stephen J. Feaster, Shinnston; Gordon Minns, Jr., Spencer; Ray W. Gandee, South Charleston; and Joseph E. Dressler, St. Albans.

Ted T. Lewis and Deleno H. Webb III, both of St. Marys; Steven M. White, Terra Alta; Lee H. Pratt, Vienna; Harry H. Ballard, Welch; James R. Barton, Weston; and Ronald A. Fawcett, Perry M. Kalis, Phillip J. Peters, Howard T. Phillips III, and Edward P. Polack, all of Wheeling.

Messrs. Bensenhaver and Webb recently were awarded scholarships of $4,000 each by the West Virginia State Medical Association (see story in General News Section).

• **Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.**

Dr. Chamberlain Awarded Fellowship

Dr. C. Richard Chamberlain, Jr., Associate Professor of Pathology, has been chosen by the Board of Directors of the American Heart Association to receive one of its awards as a Fellow in Medical Education.

Recipients of the award are given an opportunity to receive training in a Department of Research in Medical Education. They also participate in the evaluation of pilot projects in continuing physician education undertaken by the Heart Association.

Doctor Chamberlain will begin his one-year Fellowship on July 1 at the University of Illinois College of Medicine.

A member of the WVU faculty since 1961, Doctor Chamberlain received his M.D. degree from the University of Virginia College of Medicine and took a residency in pathology there.

Resident Receives Honor

Dr. Trevelyn F. Hall, Resident in Otolaryngology at the Medical Center, was honored on April 20 at a meeting of the Pittsburgh Otologic Society.

In a competition sponsored by the Society for residents in otolaryngology at the University of Pittsburgh and WVU, a paper prepared by Doctor Hall won first prize of $100. The title of his paper is "The Ototoxicity of Salicylate Therapy."

Doctor Hall is a native of Fairmont.

Papers Presented in Pittsburgh

Three members of the faculty of the School of Medicine presented papers at the third annual meeting of the Ohio Valley Cardiovascular Society at the University of Pittsburgh, April 7-8.

The WVU speakers and their subjects were: Dr. Paul Davidson, Assistant Professor of Medicine, "Abnormal Carbohydrate Metabolism in Coronary Artery Disease"; Dr. Vicente Anido, Associate Professor of Clinical Pathology, "Tissue Distribution of Creatine Phosphokinase Isozymes"; and Dr. Alphonse Edmundowicz, Assistant Professor of Medicine, "Creatine Phosphokinase in Cardiovascular Disease."

The Society is composed of the faculty members in the divisions of cardiovascular disease in the medical schools of the University of Pittsburgh, Ohio State University, and WVU.

Many overweight patients can benefit from the appetite control provided by the sustained anorexigenic-tranquilizing action of BAMADEX SEQUELS: anorexigenic action of amphetamine; tranquilizing action of meprobamate; prolonged action through sustained release of active ingredients.

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DEXTRO-AMPHETAMINE SULFATE (15 mg.) WITH MEPROBAMATE (300 mg.) SUSTAINED RELEASE CAPSULES

to help establish a new dietary pattern

Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Lederle

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE American Medical Association proposed that Congress set up a National Commission on Health Resources and Medical Manpower with broad powers to supervise the drafting of physicians for military service.

The AMA recommendation was presented by Dr. Albert H. Schwichtenberg, chairman of the AMA Council on National Security, at a Senate Armed Services Committee hearing on S. 1432 which would provide for a four-year extension of the present draft law expiring June 30.

Other AMA recommendations for modification of the doctor draft program included:

—Expansion of the physician draft pool to include women doctors.

—Making subject to draft call foreign physicians under 35 years of age, with permanent visas or who have subsequently become citizens, and who may not be subject to call because they were not deferred from induction while under age 26.

—Limiting credit for fulfillment of the draft obligation to only service performed in the armed services (Under the old law, service in the Public Health Service could satisfy a physician's obligation for active military duty).

—Routine transfer, upon completion of an internship, of the jurisdiction of physicians to the local draft board serving the area in which the physician is engaged in training or practice.

—Changes in the pay and promotion policies for military physicians designed to increase the retention of career military physicians.

"Our primary recommendation . . . is the creation of a National Commission on Health Resources and Medical Manpower," Doctor Schwichtenberg said. "This Commission would replace and be responsible for the functions of the present National Advisory Committee and the Health Resources Advisory Committee. This new Commission, under the direction of the President, would have the responsibility of maintaining a proper balance of health personnel, within existing resources, among the Armed Forces, other Government agencies, and the civilian population. Requests of the Secretary of Defense for health manpower in the military would be reviewed and approved by the Commission. The Commission would establish for the Selective Service System criteria for classifying, reclassifying and determining the order of selection for health personnel. Under this proposal, the present State Advisory Committees would be redesignated as State Health Manpower Committees, whose activities would be coordinated by the National Commission. It is further recommended that the Commission should be constituted from among persons of outstanding national reputation in the health-care fields, and its composition should include substantial representation from physicians in private practice."

Emergency Medical Services

The National Highway Agency announced tentative standards for emergency medical services provided for persons injured in traffic accidents.

The federal standards give the states broad authority in implementation and also are subject to comment by the states before they become final. The state programs must be in full operation before January 1, 1969, or a state could lose up to 10 per cent of its allotted federal highway construction funds.

Although the federal standards apply only to traffic accidents, they are expected to necessarily set a pattern for emergency medical services generally.

Dr. William Haddon, Jr., head of the National Highway Safety Agency, said the emergency care regulations are designed to provide quick response to accidents, sustain and prolong life through proper first aid measures, reduce the likelihood of permanent disability and prolonged hospitalization, and provide speedy transportation of accident victims to hospitals.

The federal standards would require states to:

—Appoint a full-time medical emergency services coordinator to have primary responsibility for the program.

—Prepare a comprehensive plan for emergency services throughout the state.

—Establish training, licensing and related requirements for ambulance drivers, attendants, and dispatchers.

—Coordinate ambulance and other emergency medical care systems, including requiring ambulances to carry two-way radios hooked up with the police and hospitals.

—Provide first aid training and refresher courses for emergency service personnel and policemen and firemen, and encourage first aid instruction for the public.

Other draft regulations with medical aspects:

—Make physical and eyesight examinations for driver licensing.

—Do compulsory blood tests for alcohol on drivers in accidents.

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Obituaries

EDWIN CAMERON, M. D.

Dr. Edwin Cameron, who practiced in West Virginia many years ago, died on April 6 in Clay City, Kentucky. He was 67.

A native of Nova Scotia, Doctor Cameron received his M.D. degree in 1927 from the Dalhousie University Faculty of Medicine. He had been located in Morgantown, Martinsburg and New Martinsville before leaving the State in 1940. He served as Berkeley County Health officer in the early 1930's.

Doctor Cameron was a former member of the Monongalia and Eastern Panhandle medical societies and the West Virginia State Medical Association.

After leaving the State, Doctor Cameron served as Executive Secretary of the Delaware State Board of Health, and at the time of his death, he was a health officer in Kentucky.

Survivors include the widow, Mrs. Molly Cameron; two daughters, Mrs. Robert Dowd of Seaford, Delaware, and Mrs. Ann Burke of Camden, New Jersey; a son, Dr. Donald Cameron of Wilmington, Delaware; and 13 grandchildren.

F. CARL CHANDLER, M. D.

Dr. F. Carl Chandler of Bridgeport died unexpectedly on April 22 in Fort Lauderdale, Florida. He was 62.

A native of Frame, West Virginia, Doctor Chandler attended West Virginia University and received his M.D. degree from the University of Louisville. He practiced medicine in Bridgeport until 1959, when he retired from active practice.

He was an honorary member of the Harrison County Medical Society, the West Virginia State Medical Association and the American Medical Association. For more than 27 years he served as a member of the Harrison County Board of Education.

Survivors include the widow, Mrs. Leona Chandler; a son, Carl of Hollywood, California; a daughter, Suzanne, at home; two brothers, Dr. Jarrett Chandler of Philippi and James D. Chandler of Huntington; five sisters, Mrs. Dovener Faber of Charleston, Mrs. Tom Hazlett, Mrs. Marie Young, and Miss Jewell Chandler, all of Philippi, and Mrs. Ann Martin of Homestead, Florida.

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JOHN MORGAN FOLEY, M. D.

Dr. John M. Foley, 48, of Frankford, died on April 10 at his home.

Doctor Foley was born in Washington, D. C., received a B.S. degree from West Virginia University in 1948, and his M.D. degree in 1950 from the Medical

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College of Virginia. He served his internship at the U. S. Naval Hospital at Portsmouth, Virginia.

He was a member of the Greenbrier Valley Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the mother, Mrs. Pearl Foley of Frankford; and two brothers, Richard of Frankford and Dan of Fort Lauderdale, Florida.

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HERBERT VOLNEY KING, M. D.

Dr. Herbert V. King of Morgantown died on April 30 after a brief illness. He was 84.

A native of Bellaire, Ohio, Doctor King received his M. D. degree in 1905 from the University of Minnesota College of Medicine. He was an eye, ear, nose and throat specialist in Morgantown until his retirement in 1965.

Prior to moving to Morgantown in 1920, Doctor King practiced in Wisconsin, Nevada and Arizona.

He was an honorary member of the Monongalia County Medical Society, the West Virginia State Medical Association and the American Medical Association. He was a former President of his local medical society.

He served one term in the West Virginia House of Delegates in the early 1940s.

Survivors include the widow; two sons, Edwin D. of Charleston and Herbert W. of New Martinsville; three daughters, Mrs. Ralph Ryan of Morgantown, Mrs. Sam Capiot of Greensboro, Pennsylvania; and Mrs. Frank Thompson of St. Louis, Missouri; six grandchildren and four great grandchildren.

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PATRICK LAMB GORDON, M. D.

Dr. Patrick L. Gordon, 93, who had practiced medicine in Charleston and surrounding coal fields for many years, died on April 11 at his home in Lexington Park, Maryland.

A native of Camden, North Carolina, Doctor Gordon received his M.D. degree in 1898. He served as Secretary of the Kanawha Medical Society in 1914, but had been an honorary member of the Fayette County Medical Society, the West Virginia State Medical Association and the American Medical Association for almost 20 years.

He was a member of the Charleston City Council in 1915-17.

Survivors include two sons and a daughter.

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County Societies

B-R-T

Dr. Alvin L. Watne of Morgantown was guest speaker at the regular monthly meeting of the Barbour-Randolph-Tucker Tri-County Medical Society, which was held in Philippi on April 20.

Doctor Watne, Associate Professor of Surgery at the West Virginia University School of Medicine, discussed current chemotherapy in the treatment of solid tumors. He gave the history of development of chemotherapeutic agents for the treatment of carcinoma and classified the types of agents used and their clinical structures.

Dr. James M. Carhart was welcomed as a new member of the Society.

Twenty members and guests attended the meeting. —A. Kyle Bush, M. D., Secretary.

* * * *

CABELL

The Rev. Dr. Paul B. McCleave, Director of the Department of Medicine and Religion of the American Medical Association, was guest speaker at the regular monthly meeting of the Cabell County Medical Society which was held at the Holiday Inn in Huntington on April 13.

Doctor McCleave's topic was "Modern Medicine: The Physician and the Clergyman." He discussed the physical, spiritual, emotional and social phases of total health.

Seventy members and guests attended the meeting.

A special business meeting of the Cabell County Medical Society was held at Cabell-Huntington Hospital on April 27 with 42 members present.

The principal item of business was discussion of the business and occupation tax that the City of Huntington had recently levied on professions. It was brought out that the Cabell County Dental Society and the Cabell County Bar Association had organized to force a court test on the legality of the city tax.

The Medical Society adopted a motion providing that it give financial assistance to the bar association in its court action.—Harold N. Kagan, M. D., Secretary.

* * * *

FAYETTE

Dr. Joseph T. Skaggs of Charleston presented a paper on "Clinical Allergy" at the regular monthly meeting of the Fayette County Medical Society, which was held at Laird Memorial Hospital in Montgomery on May 3.

Doctor Skaggs' paper centered mainly about allergic reactions from bees and related hymenoptera and to drugs, including penicillin.—Joe N. Jarrett, M. D., Secretary.

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McDOWELL

The regular monthly meeting of the McDowell County Medical Society was held at Grace Hospital in Welch on April 12, with 12 members and guests present.

Dr. R. E. Burger presented a film on "Oral Cancer," and the movie was discussed by Dr. J. C. Ray.

Dr. Robert Hansen of Welch was admitted to membership in the Society—J. C. Ray, M. D., Secretary.

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MERCER

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, was guest speaker at the regular monthly meeting of the Mercer County Medical Society which was held in Bluefield on April 17.

Doctor Flood gave an informal talk on problems facing organized medicine and discussed some of the plans for the 100th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in August.

Dr. Harold Selinger, a cardiologist from Charleston, also was a guest at the meeting.

Dr. Frank J. Holroyd discussed the current status of the American Medical Association's Disability Insurance Program.—John J. Mahood, M. D., Secretary.

MONONGALIA

Dr. George G. Green of the Department of Radiology at the WVU Medical Center presented the scientific program at the regular monthly meeting of the Monongalia County Medical Society which was held in Morgantown on April 4.

Doctor Green presented an interesting lecture on nuclear medicine.

The Society admitted to membership Dr. Walter A. Bonney, Jr., of the WVU School of Medicine, and voted a donation of $80 to sponsor a campership at Camp Kno-Koma, a camp for diabetic children.—Robert Greco, M. D., Secretary.

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RALEIGH

Dr. Thomas F. O'Brien of Winston-Salem, North Carolina, presented the scientific program at the regular meeting of the Raleigh County Medical Society, which was held in Beckley on March 16.

Doctor O'Brien, Assistant Professor of Medicine and Chief of Gastroenterology at The Bowman Gray School

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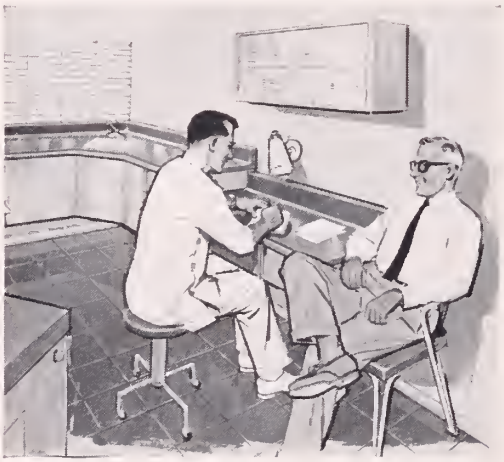

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of Medicine, gave an interesting paper on "The Medical and Surgical Implications of Recent Developments in Fat Absorption."

The Society voted to endorse the proposed Southern West Virginia Appalachian Regional Demonstration Health Project. Dr. Worthy W. McKinney, President of the Society, appointed himself and Drs. George A. Miller and Forest A. Cornwell to the Raleigh County Appalachian Steering Committee of the Southern West Virginia Appalachian Regional Demonstration Health Program

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The regular monthly meeting of the Raleigh County Medical Society was held in Beckley on April 20 with 45 members and guests in attendance.

A feature of the April meeting was a panel discussion of "The Proposed Comprehensive Medical Service Programs for Raleigh County to be Funded by the Office of Economic Opportunity." Panelists included Drs. Asa Barnes and Sherl J. Winter; Mr. Gibbs Kinderman, Director of the Raleigh County Community Action Association; and Miss Wendy Goebel of the Office of Economic Opportunity in Washington, D. C.

The Society appropriated $80 to sponsor a two-week campership at Camp Kno-Koma for one diabetic child. —Forest A. Cornwell, M. D., Secretary.

Radiology:
KARL J. MYERS, M. D.

Pathology:
S. D. WU, M. D.

Surgery:
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Fourth Vice President: Mrs. Robert W. Bess, Jr., Westernport, Md.
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Recording Secretary: Mrs. Joe N. Jarrett, Oak Hill
Corresponding Secretary: Mrs. William T. Lawson, Fairmont
Parliamentarian: Mrs. D. E. Greeneltch, Wheeling

KANAWHA

"We Care for Our Youth" was the theme for the regular monthly meeting of the Woman's Auxiliary to the Kanawha Medical Society, which was held in Charleston on March 14.

Three guest speakers elaborated on different phases of problems concerning young people. The speakers were: Mrs. Hope Stewart, R.N., Supervisor of the Kanawha County School Health Service; Mr. John R. Shomo of the Kanawha-Charleston Health Department; and Mr. Joseph C. Taylor, Director of Psychological Services for Kanawha County Schools.

Drs. A. A. Abplanalp, R. O. Dawson and J. L. Mangus, members of the Advisory Board to the Auxiliary, also were guests at the luncheon meeting at The Press Club.

Mrs. Hu C. Myers of Philippi, President of the Woman's Auxiliary to the West Virginia State Medical Association, was a special guest at a tea sponsored by the Kanawha Medical Society Auxiliary on April 11.

The function, at the home of Dr. and Mrs. George V. Hamrick, honored past presidents of the Kanawha Auxiliary and those members who had served as State President.

New officers of the Woman's Auxiliary to the Kanawha Medical Society were installed during a picnic at the home of Dr. and Mrs. John J. Schaefer in Charleston on May 9.

Mrs. J. A. B. Holt installed the following officers:

Mrs. J. L. Mangus, President; Mrs. George Hamrick, President Elect; Mrs. Page Seekford, First Vice President; Mrs. D. Brown Barber, Second Vice President; Mrs. James H. Walker, Third Vice President; Mrs. J. L. Berkley, Fourth Vice President; Mrs. Grover Swoyer, Recording Secretary; Mrs. Alva Deardorff, Treasurer; and Mrs. Willis D. Garrard, Corresponding Secretary.

The retiring President, Mrs. A. A. Abplanalp, thanked the officers and committee chairmen for their cooperation and work during the past year.

Mrs. Mangus announced several appointments for her term of office.

Hostesses for the picnic were Mrs. William Ellswood and Mrs. Marcel Lambrechts.—Mrs. H. A. Jackson, Publicity Chairman.

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MARION

Mrs. Robert J. Sidow was installed as President of the Woman's Auxiliary to the Marion County Medical Society at a luncheon meeting on May 2.

Mrs. James Wotring, the retiring President, presided. Mrs. J. J. Jenkins, Chairman of the Nominating Committee, presented the following slate of officers in addition to Mrs. Sidow:

Mrs. Kenneth D. Bailey, President Elect; Mrs. Harry Fleming, Vice President; Mrs. John W. Kramer, Recording Secretary; and Mrs. John J. Coogle, Treasurer. Mrs. Robert Janes, Immediate Past President, was the installing officer.

Mrs. Wotring was presented with a silver bowl in appreciation of her leadership.

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MONONGALIA

New officers of the Woman's Auxiliary to the Monongalia County Medical Society were installed during a luncheon meeting in Morgantown in May.

Installed were: Mrs. Walter H. Moran, Jr., President; Mrs. W. Merle Warman, President Elect; Mrs. John H. Wolfe, Jr., Secretary; and Mrs. Thomas H. Howes, Treasurer.

Mrs. George A. Curry of Morgantown, a Past President of the Woman's Auxiliary to the West Virginia State Medical Association, presided at the installation ceremony.

More than 20 members attended the luncheon.

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OHIO

The Woman's Auxiliary to the Ohio County Medical Society sponsored its annual spring dance at Oglebay Park in Wheeling on May 20.

Co-chairmen for the affair were Mesdames William F. Park and Herman Rubin.

Proceeds from the dance are to be turned over to the Medical Careers Loan Fund.

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RALEIGH

Mrs. George A. Miller has been elected President of the Woman's Auxiliary to the Raleigh County Medical Society.

Mrs. Miller's election came at the April meeting of the Auxiliary, which was held in Beckley.

Other new officers for the coming year are: Mrs. A. G. Bowles, President Elect; Mrs. Charles W. Nelson, Vice President; Mrs. Lyle Boyea, Recording Secretary; Mrs. C. Richard Daniel, Corresponding Secretary; and Mrs. Wade Rardin, Treasurer. Mrs. Everett B. Wray, Jr., is the outgoing President.

The Auxiliary voted a donation of $525 to AMA-ERF. Part of this money was donated in memory of Dr. and Mrs. F. L. Banks, Dr. McRae C. Banks, Dr. A. G. Bowles, Dr. Clark Kessel, and Dr. Albert D. Kistin.

Other donations approved included $50 to the Raleigh County Library and $50 to the YMCA.

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4. He refuses to accept the tried and proved methods of medical research and proof. He clamors constantly for "medical investigation" and recognition, but he avoids a test or stops short of giving the data needed for a scientific evaluation.
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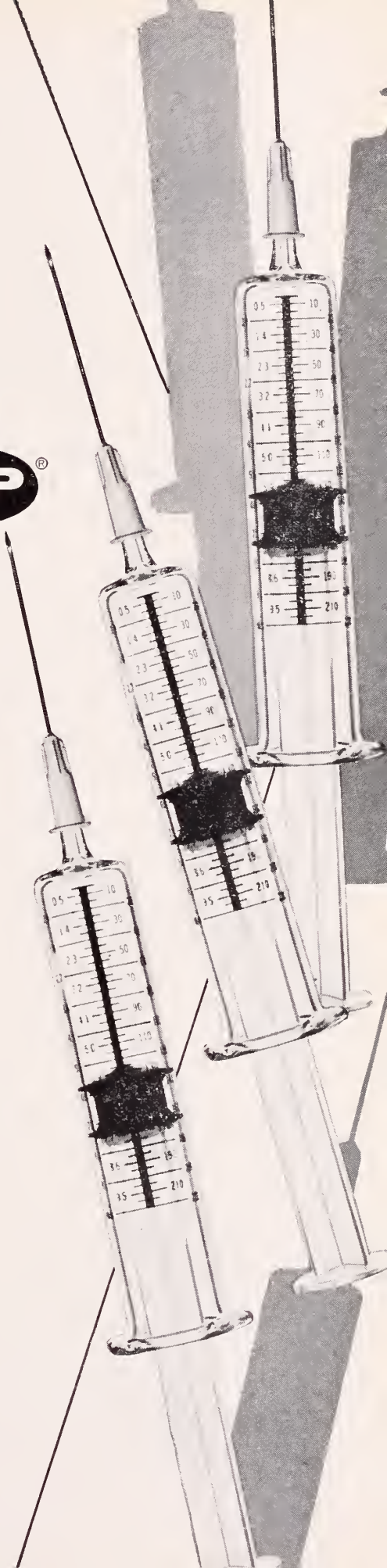

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The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston, W. Va. 25324

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50c per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

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The West Virginia Medical Journal

Vol. 63, No. 7 July, 1967

Waldenström's Macroglobulinemia

Alfred K. Pfister, M. D., James H. Getzen, M. D., and Grover B. Swoyer, M. D.

Waldenström's macroglobulinemia is characterized by proliferation of an abnormal "lymphocytoid" cell and the presence of high molecular weight globulins (macroglobulins). The lymphocytoid cell probably is the source of the increased amounts of macroglobulin. Normally, there is a small (less than five per cent) amount of macroglobulin present in the serum; whether or not the increased amount of macroglobulin found in Waldenström's macroglobulinemia is qualitatively different from normal macroglobulin is unknown.

The lymphocytoid cell is an intermediate form between the lymphocyte and the plasma cell. Recent evidence indicates that antigenic stimulation causes transformation of the small lymphocyte into the plasma cell.[1, 2] It is possible that in Waldenström's macroglobulinemia a persistent antigen (infectious?) has caused transformation of the small lymphocyte into the more immunologically active "lymphocytoid" cell which produces macroglobulin.

The present review of three cases of Waldenström's macroglobulinemia illustrates the application of various procedures in identifying proteinopathies and in selecting guiding therapy.

Serum electrophoresis has gained wide acceptance as a tool for identifying protein abnormalities but newer techniques have made it possible to further classify serum proteins. Use of immunophoresis has identified four classes of serum proteins with antibody activity—IgG (gamma G), IgA (gamma A), IgM (gamma M) and IgD (gamma D).[3] Concentration of these immunoglobulin classes may be increased or decreased in various disorders of the immune cells (lymphocytes and plasmacytes) in the body.

Submitted to the Publication Committee, November 18, 1966.

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Another method of delineating protein abnormalities is by serum ultracentrifugation. Proteins separate at rates related to their molecular weight. The immunoglobulins IgG and IgA are in the 7 S range and the high molecular weight macroglobulins (IgM) appear in the 19 S range (Figure 1).

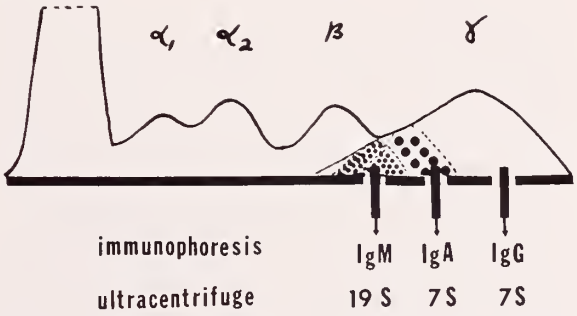

Figure 1. Diagram illustrates relationship of immunoglobulins (IgG, IgA and IgM) to serum protein electrophoresis and their sedimentation class obtained by ultracentrifugation.

Case 1.—A 77-year-old white woman developed intermittent upper abdominal discomfort associated with vomiting during the six weeks prior to admission. During the two months before her admission, she had anorexia and a 15-pound weight loss. The patient had experienced frequency and nocturia over the preceding half year, with no previous history of renal disease.

Physical examination revealed a pale, moderately asthenic, white female with a blood pressure of 140/90, pulse of 108 per minute, respirations of 22 per minute and temperature of 98.4 F. She had generalized diminution of skin turgor. Scattered crepitant rales were audible over the right lung base. She had some tenderness to deep palpation in the epigastrium.

The initial white blood count was 6,600 cells cu. mm. with a differential of 58 per cent segmented neutrophils, 1 per cent band neutrophils and 41 per cent lymphocytes (2 per cent atypical). The hemoglobin was 6.5 Gm. per cent and hematocrit was 19.5 vol. per cent. Marked rouleaux formation was evident on the peripheral blood smear. The sedimentation rate (Westergren) was 75 and the BUN was 115 mg. per cent. Urinalysis showed specific gravity of 1.004 and 30 mg. of albumin. The 2-hour p.c. sugar, serology, Bence Jones urine protein, prothrombin time, alkaline phosphatase, thymol turbidity, SGOT, LE preps, urine colony count and urine acid-fast cultures were all unremarkable. A serum electrophoretic pattern showed a total protein of 10.1 Gm. per cent with the following distribution: albumin 2.8 Gm. per cent, alpha 1 globulin 0.4 Gm. per cent, alpha 2 globulin 0.8 Gm. per cent, beta globulin 0.9 Gm. per cent and gamma globulin 5.2 Gm. per cent. A symmetrical homogenous band was present between beta and gamma globulin. The serum viscosity was elevated to 2.8 units* and the Sia water test was negative. A bone marrow aspiration showed 75 per cent lymphocytes and several atypical "lymphocytoid" forms. On ultracentrifugation, 36 per cent of the serum proteins were in the macroglobulin class.

The patient was discharged on an anti-uremic regimen, multivitamins, and 100 mg. cytoxan daily. Her course, illustrated in Figure 2, demonstrated that her globulins fell with chemotherapy and continued to decrease even after treatment had been discontinued. The patient expired seven months later of peritonitis secondary to a ruptured colonic diverticulum. At postmortem examination the spleen was slightly enlarged and the liver was normal in size. Atypical lymphocytes were in the lymph nodes and bone marrow, but there was no infiltration of the parenchymal organs. The kidneys were slightly decreased in size (120, 130 Gm.) with scarring and hyalinization of many glomeruli. The renal parenchyma had a fine interstitial fibrosis.

Case 2.—This 69-year-old white woman noticed the appearance of ecchymotic areas in her lower extremities two days prior to admission; the lesions gradually extended over her trunk and upper extremities during the next 48 hours and became confluent. She had experienced nontender swelling in the cervical region for the previous two weeks. The patient stated that 12 years earlier her physician diagnosed "protein" in her urine and "nephritis."

Physical examination showed a thin white lady with blood pressure of 170/80, pulse of 70 per minute, respirations of 16 per minute and temperature of 103.8 F. rectally. A flame-shaped hemorrhage was present in the right fundus. Nontender lymphadenopathy was present in the cervical, axillary and inguinal areas. A grade 2/6 midsystolic apical murmur was audible. A soft spleen was palpated three fingerbreadths below the left costal margin. Scattered ecchymotic areas were present on both sides of the trunk and on the upper and lower extremities.

Laboratory examination showed the hemoglobin 6.7 Gm. per cent and the hematocrit 22

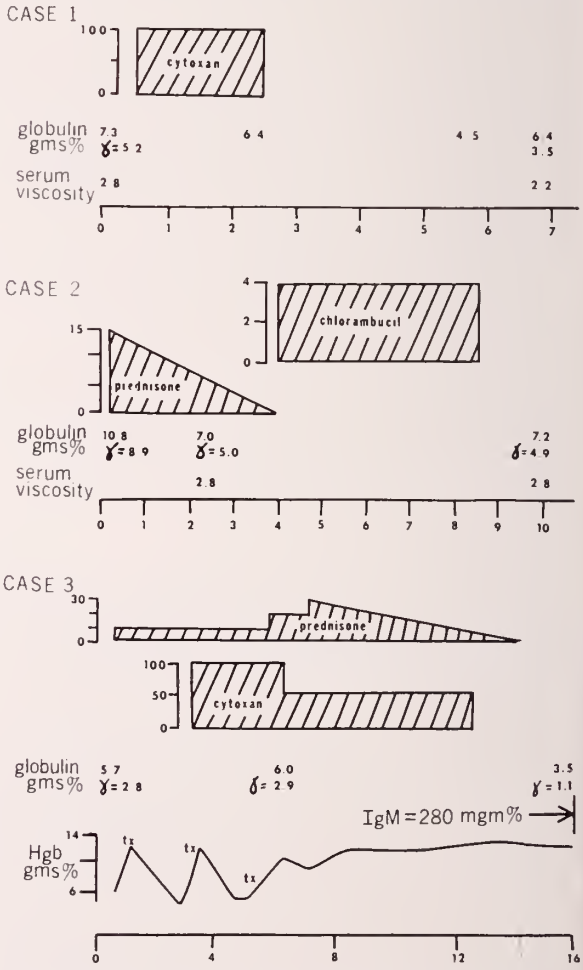

Figure 2. Illustration shows the changes in globulins and gammaglobulins under chemotherapy in the three causes described in the text. Note presence of increased IgM in Case 3 although remainder of protein parameters are unremarkable (normal IgM up to 116 mgms%). Therapy duration is indicated in months.

* 1.4—1.8 normal range.

vol. per cent. The white blood count was 23,000 cells cu. mm. with a differential of 44 per cent segmented neutrophils, 1 per cent band neutrophils, 1 per cent eosinophils and 53 per cent lymphocytes (about half atypical). The sedimentation rate (Westergren) was 61. Marked rouleaux formation was present on the peripheral smear. Platelet counts were 129,000 and 63,000 cells/cu. mm. Urine analysis showed 300 mg. of albumin, many red cells/H.P.F., 50-60 white cells/H.P.F., and 5-6 coarsely granular casts/L.P.F. The BUN was 46 mg. per cent. The urine contained Bence-Jones protein. Serum electrophoresis showed a total protein of 13.4 Gm. per cent with 2.6 Gm. per cent albumin, 0.4 Gm. per cent alpha 1 globulin, 0.9 Gm. per cent alpha 2 globulin, 0.6 Gm. per cent beta globulin, 8.9 Gm. per cent gamma globulin with an abnormal homogeneous band in the gamma globulin region which stained intensely with periodic acid-Schiff (Figure 3). Blood coagulation studies and liver function tests were normal. The bilirubin, direct Coomb's test, serology, cold agglutinins and L.E. preparations were unremarkable. A Sia water test was positive. Serum ultracentrifugation confirmed the diagnosis of macroglobulinemia. An intravenous pyelogram showed no structural abnormalities. A bone marrow examination showed 73 per cent lymphocytes with many atypical-appearing "lymphocytoid" cells. The patient was treated for *E. Coli* bacteremia and recovered. She was discharged on steroids and her hemogram improved. Chlorambucil therapy was instituted shortly after discharge. Her course is shown in Figure 2.

Case 3.—A 65-year-old white woman was admitted for an evaluation of "anemia." About one and one-half years prior to admission, she had received many transfusions and hematemics during a seven-month period. Six months before admission, subtotal gastrectomy was done at another hospital because of achlorhydria and a "stomach ulcer" seen on fluoroscopy. Her hospital records at that time indicated that at laparotomy her spleen was enlarged. No gastric ulcer was found. A postoperative wound infection occurred. Leukopenia was present during that hospitalization and responded to glucocorticoid therapy. Her hemogram improved, with a persistent lymphocytosis. Two months prior to her present admission the patient had an episode of intra-ocular hemorrhage. There were no other bleeding episodes.

Physical examination revealed an obese, anxious, white woman with blood pressure of 170/90, pulse of 86 per minute, respirations of 18 per minute, and temperature of 96.8 F. orally. Flame-

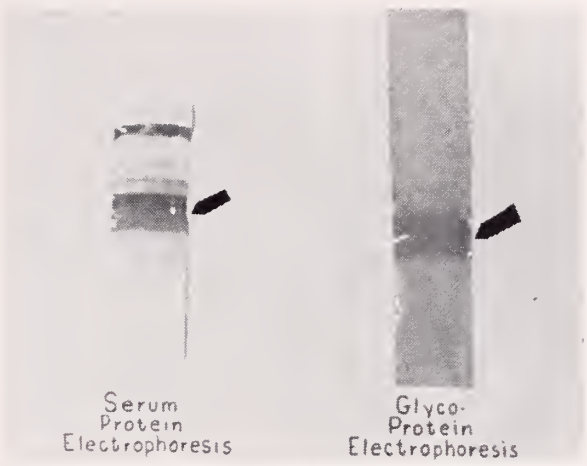

Figure 3. Marked increase in gamma globulins seen on serum paper electrophoresis using cellulose acetate paper and Ponceau-S stain (left) stained intensely with periodic-acid Schiff stain (right). This indicates the presence of high carbohydrate content macroglobulins.

shaped and blot hemorrhages were in the left fundus, with a soft exudate. The retinal veins were tortuous. A grade 2/6 soft, midsystolic, apical murmur was audible. The liver edge was firm and nontender and was palpated two fingerbreadths below the right costal margin. The spleen was enlarged two fingerbreadths below the left costal margin.

Laboratory examination showed the hemoglobin was 7.2 Gm. per cent, and the hematocrit 21 vol. per cent. The white blood count was 6,150 cells per cu. mm. with a differential of 45 per cent segmented neutrophils, 1 per cent band neutrophils, 2 per cent eosinophils, and 52 per cent lymphocytes with an occasional atypical lymphocyte. The reticulocyte count was 1.0 per cent. Serum bilirubin, stools for occult blood, urine urobilinogen, urine analysis, serology, glucose, Hamm-Crosby test for acid hemolysis, Coomb's test, uric acid, BUN, serum iron, iron binding capacity, and platelet count were all unremarkable. The latex agglutination test for rheumatoid factor was positive. By serum electrophoresis the total protein was 9.1 Gm. per cent with the following pattern: albumin 3.4 Gm. per cent, alpha 1 globulin 0.4 Gm. per cent, alpha 2 globulin 1.0 Gm. per cent, beta globulin 1.5 Gm. per cent and gamma globulin 2.8 Gm. per cent. An abnormal, dense homogeneous band was present in the beta globulin region and showed an intense stain on electrophoresis, using periodic acid-Schiff stain. A Sia water test was positive. The bone marrow aspiration had considerable increase in the myeloid to erythroid ratio with predominance of lymphocytes and "lymphocytoid" cells (Figure 4). A red cell survival time using chromium 51 had a half-life of 18.6 days with a predicted normal of 20.0 days.

There was no splenic sequestration. Serum ultracentrifugation performed at another institution demonstrated an increase in the 19 S globulins characteristic of essential macroglobulinemia. This patient's further course is plotted in Figure 2.

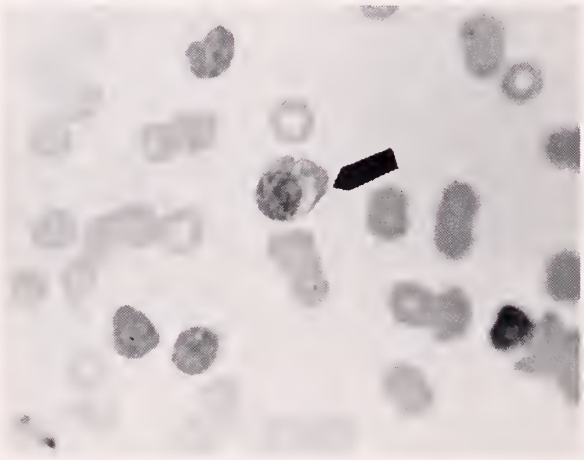

Figure 4. Lymphocytoid cell (arrow), with several mature lymphocytes for comparison. Notice rouleaux formation.

Comment

The clinical findings of Waldenström's macroglobulinemia are protean. Fatigue, weakness and weight loss occur in the majority of cases.[4] Visual disturbance, bleeding episodes and dyspnea also are common manifestations and are directly related to the increase in macroglobulins which induce plasma hyperviscosity.[4, 5] Macroglobulins have the ability to alter capillary permeability, alter coagulation factors, and may be responsible for the frequent ocular complaints and retinal hemorrhages.[5, 6]

The physical examination commonly will show diffuse lymphadenopathy, hepatosplenomegaly and flame-shaped retinal hemorrhages with venous dilation and soft exudates. In a small percentage of cases, the patient will be asymptomatic.

The most striking laboratory findings are the high sedimentation rate and hyperglobulinemia. Although in the cases presently reported the patients were anemic and had lymphocytosis and atypical lymphocytes in the peripheral blood, this does not occur frequently enough to be of diagnostic value. Rouleaux formation, demonstrated in all of the present cases, is a clue to a dysproteinemia. The Sia water test, originally used for the diagnosis of kala-azar, has been widely adopted to detect macroglobulinemia.[7] In this test a drop of serum is placed in 10 cc's. of distilled water in a test tube. Turbidity appears within 10 seconds if macroglobulins are present. Rare false positives and negatives can occur. Serum viscosity measurements, using a viscosimeter, are easily determined; the height of the viscosity seems to correlate well with the quantity of macroglobulins present, although the relationship is not linear.[5] It should be emphasized, however, that an increase in serum viscosity can occur in conditions other than macroglobulinemia.

Serum protein electrophoresis is of considerable help in identification of abnormal globulins. A symmetrical, narrow, sharp peak in the globulin region usually indicates myeloma protein or macroglobulins. In macroglobulinemia the band may appear anywhere in the globulin region, but most commonly it is found in or near the gamma globulin. Since macroglobulins are high in carbohydrate content, electrophoresis with periodic acid-Schiff stain will produce an intense red color in the macroglobulin band.

The ultimate diagnosis rests on the demonstration of an increase of 19 S globulin by serum ultracentrifugation. Immunodiffusion and immunophoresis may demonstrate an increase in gamma M (IgM) globulin (Case 3).

Treatment is directed to restoring a normal hemogram and reducing the serum viscosity. Chlorambucil[8] and cyclophosphamide[9] have been used successfully in restoring these parameters to normal levels.

Frequent plasmapheresis therapy has been effective in lowering the serum viscosity when symptoms of hyperviscosity become disabling.[5, 10] Corticosteroids can be beneficial in patients with hemolytic anemia or thrombocytopenia; whether these agents have any effect on the "lymphocytoid" cells is unknown.

Summary

Three cases of Waldenström's macroglobulinemia are reported. All patients showed marked hypergammaglobulinemia and an abnormal band on serum protein electrophoresis. The relatively high carbohydrate content of the macroglobulins makes serum electrophoresis with periodic acid-Schiff stain a valuable screening test. The Sia water test and serum viscosity measurements, although less specific for macroglobulinemia, are useful as diagnostic and therapeutic guidelines. Ultracentrifugation and immunodiffusion techniques are employed to arrive at a more specific diagnosis. Chemotherapy can effectively reduce the highly viscous macroglobulins when symptoms of hyperviscosity occur; when these symptoms become severely disabling, however, plasmapheresis therapy should be used.

Requests for reprints should be mailed to the Reprint Section, Medical Associates, Memorial Hospital, Charleston, West Virginia.

References

1. Hirschhorn, K., Kolodny, R. L., Hashem, N. & Bach, B.: Mitogenic Action of Phytohemagglutinin (letter to the Editor), Lancet 2:305, 1963.
2. Elves, M. W., Roath, S., Taylor, G. & Israels, M. C.: The *In Vitro* Production of Antibody Lymphocytes, Lancet 1:1292, 1963.
3. Fahey, J.: Antibodies and Immunoglobulins, J.A.M.A. 194:255, 1965.
4. Bayrd, E., Hagedorn, E. D. & McGuckin, W. F.: Macroglobulinemia, J.A.M.A. 193:724, 1965.
5. Fahey, J. L., Barth, W. F. & Solomon, A.: Serum Hyperviscosity Syndrome, J.A.M.A. 192:464, 1965.
6. Schmidt, K. P., Caldwell, J. R., Basinski, D. H. & Fine, G.: Hypertension and Retinopathy in Waldenström's Macroglobulinemia, Ann. Int. Med. 63:842, 1965.
7. Ritzmann, S. E., Thurm, R. H., Truax, W. E. & Levin, W. C.: The Syndrome of Macroglobulinemia. Review of the literature and a report of two cases of macroglobulinemia, Arch. Int. Med. 105:939, 1960.
8. Clatanoff, D. V. & Meyer, O. O.: Response to Chlorambucil in Macroglobulinemia, J.A.M.A. 183: 40, 1963.
9. Bouroncle, B. A., Datta, P. & Frajola, W. J.: Waldenström's Macroglobulinemia. Report of three patients treated with cyclophosphamid. J.A.M.A. 189:729, 1964.
10. Schwab, P. J. & Fahey, J. L.: Treatment of Macroglobulinemia by Plasmapheresis, New England J. Med. 263:574, 1960.

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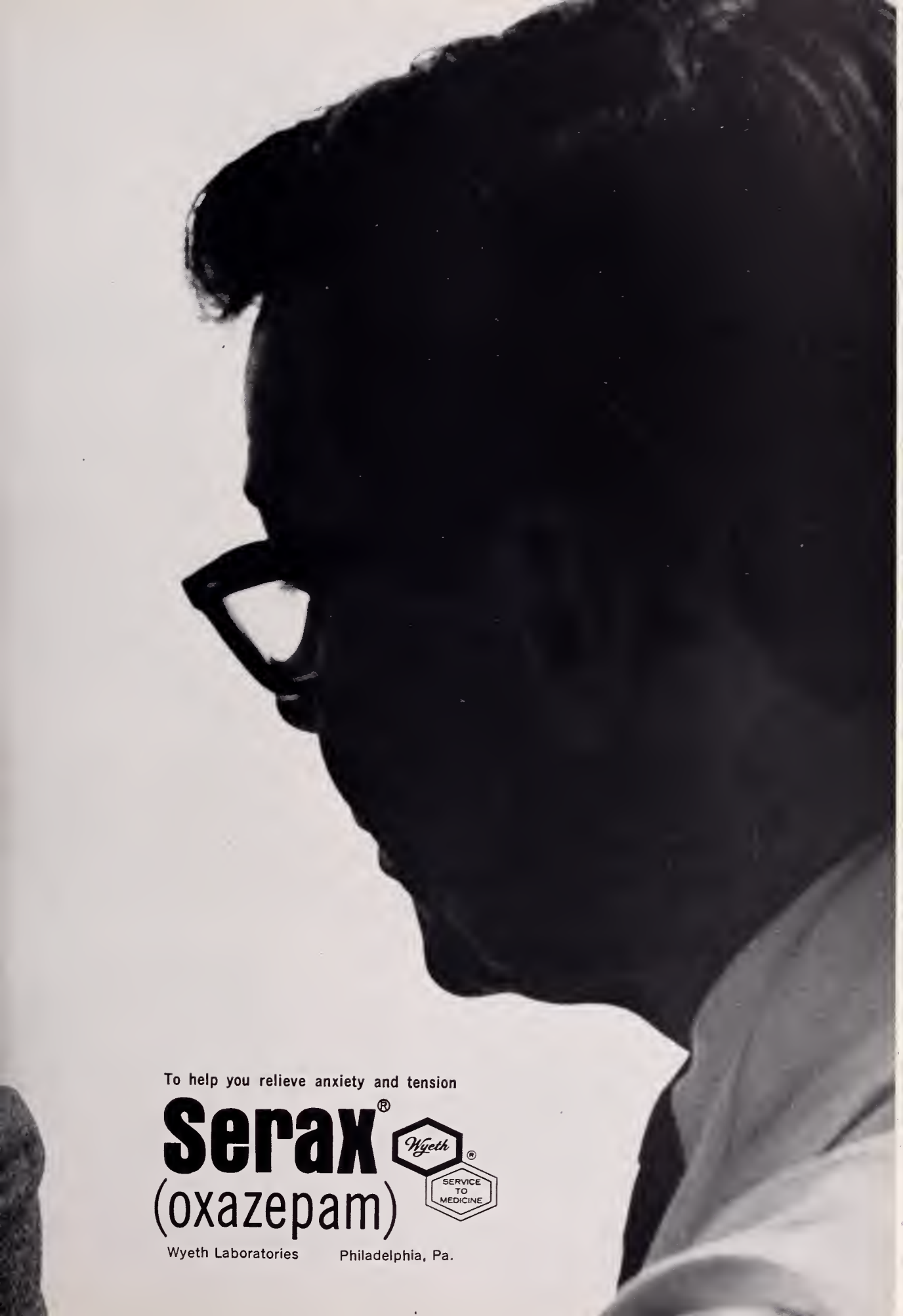
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Comprehensive Community Health Services: A Challenge for Rural Communities*

Robert R. Huntley, M. D.

DR. JOHN KNUTSON, President of the National Health Council, in his inaugural address last spring, made the following comments: "Anarchy in Health Administration is common throughout the land. The chaotic conditions resulting from lack of health planning and from lack of effective health administration are seriously hampering the nation's fight against disease and other hazards to health."

Other leaders have observed that although the United States stands first in expenditures for health services, currently spending almost 6 per cent of our gross national product for them, it stands between 7th and 13th in the world in most of the indices used to measure the effectiveness of these services—infant mortality, tuberculosis deaths and maternal mortality to mention a few.

The United States is a large and diverse country, has a wide range of living conditions and a heterogeneous population which makes comparison with health statistics of small countries with small homogenous populations somewhat unfair. Despite this, these observations indicate that many health leaders are seriously concerned about the problems of obtaining the best in health services for all the American people.

It is particularly appropriate that we consider some of these problems here today since people living in rural areas and those living in the middle of our great cities are less well served than the rest.

It also is particularly appropriate that we are talking of these problems in West Virginia, because rural leaders in this state have for many years demonstrated concern and initiative in helping to solve health problems in their communities. Miss Gertrude Humphreys, speaking in 1965 at the National Conference on Rural Health, noted that as early as 1920 local leaders in one rural county took the initiative in developing (and finding staff for) a well-child clinic in an area that had no pediatric services. In other areas rural leaders have awakened public opinion to the need for county health departments. In yet another county, the Home Demonstration Club put on a concentrated educational program to inform farm families of the importance of a proposed new hospital for their county and to encourage people to vote for the hospital levy. This hospital is now in operation, serving the people of several neighboring rural counties.

The Author

- **Robert R. Huntley, M. D., Associate Professor of Preventive Medicine and Medicine, and Milbank Faculty Fellow, the University of North Carolina School of Medicine, Chapel Hill.**

With this history of rural leadership in West Virginia in mind, I would like to discuss with you for the remainder of our session this morning three reports of National Advisory Committees concerned with various aspects of the problem of assuring the delivery of good health services to people. All three were published in 1966.

National Commission Report

The National Commission on Community Health Services was established in 1963 by the American Public Health Association and the National Health Council. Their final report was published this summer under the title, "Health is a Community Affair." The National Commission was under the leadership of Mr. Marion B. Folsom, former Secretary of Health, Education and Welfare in the Eisenhower administration, and its report contains 14 major points. I shall not list all 14, but shall discuss with you briefly the first three. The first recommendation is that "the organization and delivery of community health services must be based on the concept of a 'community of solution,' rather than primarily on political jurisdiction." Diseases (and patients) know no political boundaries—particularly the latter, even when their care is subsidized from public funds.

The second is that "communities must take the action necessary to provide comprehensive health services of high quality to all their citizens. These services must include (1) promotion of

*Presented before the 19th Annual Rural Health Conference, sponsored by the West Virginia State Medical Association, at Jackson's Mill on October 6, 1966.

positive good health by application of early detection of disease, (2) prompt and effective treatment and (3) physical, social and vocational rehabilitation of those with residual disabilities."

The third recommendation is that "every individual should have a personal physician to provide continuity in the delivery of integrated medical and medically related services."

Millis Commission Report

The final report of the Citizen's Commission on Graduate Medical Education, chaired by Dr. John Millis, President of Western Reserve University, and sponsored by the American Medical Association, contained a number of recommendations, developed after two years of careful study of the problems involved in the training of physicians. Four are closely related to the recommendation of the National Commission relative to the need for personal physicians. They are: (1) the internship should be abolished, (2) all physicians should take residency training (four years' duration on average) to prepare them for the practice of a specialty field, (3) primary medical care (synonymous with "personal physician care") should be considered a major and important field of medicine, and special residency training should be developed for physicians entering this field, and (4) state licensing laws should be changed so that the internship is no longer required, but so that a period of residency training is required for practice.

Report of Health Advisory Committee—Appalachian Regional Commission

This committee of 25 members (three from West Virginia—Dr. Paul Miller, Chairman, Dr. Allen Dyer, Dr. Mildred Bateman) was instructed to study the health problems of Appalachia and to advise the Commission on the best ways to use the limited funds available under section 202 of the Act (PL 89-4).

Section 202, the major health section of the Appalachian Act, provides for grants for construction, equipment and operation of "multicounty demonstration health facilities." This includes any facilities and services, inpatient and outpatient, that are considered necessary to the improvement of health in the region. A total of $69 million was authorized, with $21 million being appropriated initially.

As soon as this legislation was enacted, many questions arose as to the interpretation of the Act, and the manner in which the authorized funds could best be utilized to accomplish the goal of improving the people's health as a contribution to economic development. Certainly it would not make sense to attempt to spread this money evenly over the almost 19 million people in the Appalachian region. It would pay for approximately one office visit for each individual—hardly a major contribution to health!

The Health Advisory Committee first defined the major health problems of the Region and determined that facilities shortages (hospital beds, health department buildings and the like) are not a primary problem of the area—rather, the number one problem is a shortage of services of all sorts, as measured by the availability of physicians, dentists, nurses, public health workers and ancillary medical personnel. These shortages of personnel were, predictably, worse in the poorest and most rural areas in all states, including West Virginia.

Having made these observations, the Committee then paid particular attention to the importance of the word "demonstration." Most members believed that a few discrete projects should be funded. These projects should embrace single medical service areas, and utilize all available sources of funding and all available health manpower—especially physicians, dentists, and other professionals already working in the area. Such projects would have as their objectives the provision of comprehensive continuing medical and health services to the whole population of the medical service areas for which they were designed, demonstrating what is required to accomplish this objective.

The Health Advisory Committee defined comprehensive health services as including all preventive, diagnostic, treatment, rehabilitative and restorative, and environmental health services. (Note the close resemblance to the National Commission definition, developed independently).

The Committee emphasized the importance of cooperative efforts on the part of practicing physician, hospitals, health departments and other community health agencies; that is to say, the health of the public is not solely the responsibility of the practicing physician, the health department or the hospital. Any one of these groups working alone cannot insure comprehensive health services. Cooperation during planning and operation is essential.

Careful and continuous evaluation of the effectiveness of these projects also is imperative if they are truly to "demonstrate" anything worthwhile. If carefully evaluated, these demonstrations should point out both the pitfalls to be avoided and the approaches that promise to be particularly effective in future efforts at area-wide planning for health services.

The Committee also recognized that shortage of personnel is the most critical single problem and great emphasis was placed on (1) efficient organization of services with special attention to careful job description and the generation of new kinds of personnel where appropriate (particularly for home care services), and (2) involvment of institutions of higher education in the project area as future sources for needed personnel. Recruitment from "outside" in an already tight labor market likely is not a good long-term solution to the health manpower problems of Appalachia or of any other rural area.

Involvement of educational institutions means not only medical and public health schools but schools for the training of nurses, technicians, nursing assistants, home health aides and other workers.

Principles of Health Planning

To emphasize a few principles for health services planning and development: the objective should be the development, in a series of logical steps, of a program to assure delivery of comprehensive health care to all the people in a natural medical trade area or "health-shed." Development of these services will require the cooperative effort of all concerned persons in the community and in regional educational institutions, careful study of the needs and resources of the area in which projects are to be developed, and a willingness to forget many of the traditional rivalries that have kept public health, private medicine, hospitals, third-party payers and universities apart in the past. It also will require a willingness to work together (for the good of the patient) of doctors, nurses, dentists, health officers, welfare and school leaders, and hospital administrators. All these community leaders already have responsibility for some aspects of the public's health.

The four key concepts at this point in time are: (1) demonstration, (2) area-wide health services planning, (3) a comprehensive range of services and (4) evaluation. Evaluation should show that the program has improved (1) the availability of services, (2) the health of the people and (3) their economic well-being.

Now—as a check-list—what is a "comprehensive range of services" in 1966?

1. Primary care services—mostly personal physicians and dentists.

2. Institutional services—acute general hospital, extended and convalescent care, skilled nursing home, boarding home.

3. Organized home care—for discharged hospital patients and the chronically ill—nursing, physical and occupational therapy, dietary consultation, sick room loan closet, etc.—all supervised by the personal physician.

4. Community mental health (both inpatient and outpatient).

5. Organized transportation service, including ambulance service. This represents an extension of services already offered by Rescue Squads in many rural areas.

6. Other—a good clinical laboratory, blood bank, consultant physicians and dentists.

Thus, we are back where we started. Armed with a check list like this, citizens of rural West Virginia must look at their own communities; decide what the center for medical services for their own "medical trade area" is—or should be; which services can best be given from the center and which can best be given right in the neighborhood; then organize and work to see that they, their families and their neighbors have available the best that American Medicine has to offer.

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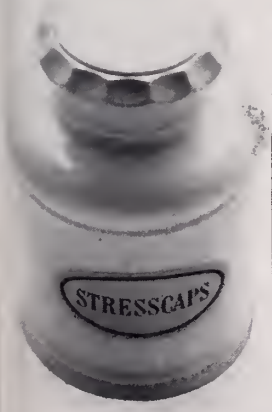

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References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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Special Article

Growth of Medical Center Library

Edward J. Van Liere, M. D.

When West Virginia University had a two-year medical school, its library was housed in the University Library. This was not a good arrangement because the University Library was a considerable distance from the Medical Building and, furthermore, many medical books and periodicals were not strictly segregated. Nothing could be done about this until the Medical Center could develop its own library.

Most of the books and periodicals acquired during the years the two-year school was in existence dealt with the basic sciences (anatomy, biochemistry, bacteriology, pathology, pharmacology and physiology), although a substantial number of clinical journals, monographs and major textbooks were also acquired. The two-year medical library in 1956 had approximately 12,000 volumes.

When the Medical Center was designed, plans were made for an adequate library to house books and periodicals for the four disciplines; medicine, dentistry, pharmacy and nursing. The library was planned by Alderson Fry, a medical librarian of wide experience. Before coming to West Virginia University, he had developed medical libraries at Meharry Medical College in Nashville, Tennessee, and at the University of Washington in Seattle, Washington. He is a well-known medical library consultant, and the Rockefeller Foundation a few years ago commissioned him to make a survey of medical libraries in the Orient, and in certain countries in South America. In essence, the Medical Center Library was well planned by an experienced and competent medical librarian.

The location of a medical library is important. Ideally, it should be located in the center of the medical complex, or as nearly in the center as practicable. If it is necessary to house the library in a separate building, such a structure should be placed immediately adjacent to the main medical building. Furthermore, arrangements should be made to make the library building as accessible as possible, preferably by means of covered passageways between the two buildings. The Medical Center Library, although not situated in the center of the medical complex, is, nevertheless, conveniently and strategically located, especially for those students taking work in the Basic Sciences Building. In point of fact, it is also convenient for those working in the hospital.

The Author

- **Edward J. Van Liere, M. D., Dean Emeritus, West Virginia University School of Medicine, Morgantown.**

No attempt will be made to give a detailed description of the Medical Center Library. Suffice it to say that it occupies the west wing of the Basic Sciences Building and contains 30,000 square feet. There are six stack levels, two of which are underground. It has a capacity of 140,000 volumes. The building is so constructed that additional stack levels may be added.

The Basic Sciences Building was completed July 1, 1957, and the Library was opened on that date. The medical books and periodicals had been transferred to the Medical Center Library during the spring and early summer of 1957.

The main entrance to the library is from the second floor of the Basic Sciences Building, which corresponds to the fifth stack level. On this floor are located the charge desk, various offices and preparation rooms, and the main reading room.

1,517 Periodicals Received Annually

Presently there are approximately 75,000 volumes in the Medical Center Library, and of this number at least four-fifths, or about 60,000 volumes, are concerned with medicine. The remaining number of volumes have to do with the other disciplines; dentistry, pharmacy and nursing. The library receives about 1,517 periodicals annually. Obviously, the periodicals are an important item so far as the annual growth of the library is concerned. Many books and monographs are acquired each year. The number of volumes in the library, therefore, is growing very rapidly.

There are presently 85 medical school libraries in the United States. These represent a huge financial investment. Besides medical school libraries there are many other medical libraries, especially in connection with hospitals, clinics, medical foundations, and the like. The Directory of the Medical Library Association lists 480 medical libraries in the United States. The annual budgets vary from about $200 to over a half million dollars. The largest budget is that of the National Library of Medicine in Bethesda, Maryland.

The number of volumes in medical libraries, as would be expected, vary greatly. The average medical library has probably somewhat less than 60,000 volumes. The largest university-centered medical library in the nation is the Francis A. Countway Library at the Harvard Medical School, which has just been completed. It brings together the collection of the Harvard and Boston Medical Libraries; the combined collection of the Countway Library is in excess of 450,000 volumes. It is hardly necessary to point out that an enormous amount of money is needed annually to support such a library, and not many medical schools could afford this.

Importance of a Good Library

It is no longer necessary to emphasize the importance of a good medical library; this fact is generally recognized. However, a few comments may be in order. The well-known medical historian of Yale, the late John F. Fulton, in 1959, wrote that one could gain an unfailing index of the vitality of a medical school by an analysis of the support given to its library by the school's administration. He wrote further that if the library budget is inadequate, the school can automatically be set down as second rate, whereas, if the budget is adequate, the school can be accepted as a "Class A" institution. Doctor Fulton thus succinctly sums up the matter.

In general, the author agrees with the sentiments Doctor Fulton expresses, but there may be extenuating circumstances. The personnel of a medical school situated in a large city, such as Chicago, Boston, Philadelphia or Washington, D. C., may have access to one or more large medical libraries which are not connected with a medical school. The author has in mind, for example, the John Crerar Library in Chicago, the National Library of Medicine in Bethesda, Maryland, and the former Boston Medical Library (now incorporated with the Harvard Medical Library). The author is familiar with at least two famous medical schools, neither of which had an outstanding library, namely the Harvard Medical School and the University of Pennsylvania School of Medicine. As already mentioned the former school has built the Francis A. Countway Library, and now has excellent library facilities, and a new library is being built at the School of Medicine of the University of Pennsylvania.

A Service to the Profession

A medical school library, although primarily designed for the use of students and members of the hospital staff, should also—especially if the school is connected with a state university—serve the medical profession in the state. The Medical Center Library is equipped to do this. The library is in a position to offer helpful services to the practicing physician. If, for example, a physician wishes to procure an article in some journal, the library will promptly send a Xerox copy of the article at a nominal charge. This is much more satisfactory than sending a bulky volume through the mails. The Medical Center Library is, of course, open to all physicians, and the library staff is ready to help in any way—indeed, it welcomes an opportunity to do so.

In summary, it may be said that the Medical Center has a very adequate library, exceedingly well planned and built. It is constructed so that additional stack levels may be added. It serves the four health disciplines; medicine, dentistry, pharmacy and nursing. Not only does it serve the students and the staff of the Medical Center, but it is equipped to serve the medical profession throughout the State. It will undoubtedly play an increasingly important role in coming years.

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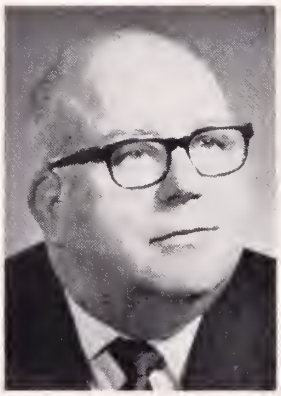

A message from . . .

The President

BANG! THIS IS WHAT WE DID

BANG! And a happy Fourth of July to you all. I'd like to set off a few firecrackers to impress on all the value of history! Our heritage is on the line this Centennial Year.

What would you do? THIS IS WHAT WE DID and much was accomplished because so many wanted things done. And yielding to demand the program for The Greenbrier shapes up like this:

Doctor Walsh of the Good Ship HOPE will lead off the Thursday session with his keynote address. Drs. Brian Blades and John Ullery will round out the morning session. A new venture will be had Thursday afternoon—A general session featuring Medicine and Religion with Bishop Brunini and Doctor Rouse providing a session on the "Doctor's Dilemma Over Present Day Morals;" The Rev. Dr. Paul McCleave will be the Moderator and many distinguished college presidents will be present. Since sexuality and auto accidents pull in audiences, come early and get a good seat! Everyone is invited, including wives and teenagers.

A dance will be held Thursday night—likewise all invited.

Friday, Drs. Charles Doan, John K. Lattimer and Dana L. Farnsworth will head the general session and Friday night all are invited to the cocktail party, dinner and Centennial Ball. Souvenirs will be given to all attending.

All these affairs are for everyone attending the meeting—I would like to extend a personal invitation to all of you to come.

I thought it would be nice to give Ed Van Liere a little formal recognition for all of his kindness to medicine and neophyte physicians. You all will be interested in this program on Medical Education—Then, Now and Tomorrow.

If the Auxiliary then will please note, arrange and bring your spouses to the general affairs—

1. Thursday 9:00 A. M. (Doctor Walsh)
2. Thursday 2:00 P. M. (Bishop Brunini—Doctor Rouse—Rev. McCleave)
3. Thursday night 9:00 P. M. (Dance—Chesapeake Hall)
4. Friday 6:30 P. M. (Cocktail Party)
   7:30 P. M. (Dinner—Centennial Ball to follow)
5. Saturday 9:30 A. M. (Van Liere Day)
6. Saturday 6:00 P. M. (Cocktail Party and Reception)

The Auxiliary, too, will be selling charms, cuff links, tie pins, etc. and the proceeds will go to the AMA-ERF—God Bless these good women for all the good work and kindness they do. And thanks to Mrs. Avanelle Myers for supplying the President's Page for June.

You can see all demands are trying to be accomplished. Don't be one of those who will have to "ask the man who" was at the affair—come to all the affairs, it is *Your Centennial Meeting.* Each affair will have the facilities to accommodate everyone. Enjoy it as much as we have in putting it together.

Come one, Come all.

RICHARD E. FLOOD, M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

THE QUALITIES OF LEADERSHIP

The subject of this editorial is a big man; his better than six-foot stature makes him a physical stand-out in any group, and the full use of his many talents endows him with a prominent image among his colleagues and associates. He is not a shrinking violet in the garden of mankind, nor indeed is he a shy person—rather he can be described as a modest person who operates with an air of confidence. At the proper time one can expect him to express his views and suggest action with an authority based upon knowledge and experience.

He greets everyone, friend or stranger, with a firm handshake accentuated by a pleasant smile and a kindly word. It is very apparent that he has inherited a mixture of chromosomes and genes which have been so arranged as to produce a man endowed with a friendly personality, the talents of positive ability, the spur of needed ambitions, the willingness to work, function together in an aura of politesse.

These attributes are not self-sustaining—he is fortunate in having an understanding and patient wife, who in addition to her homemaking duties, has adapted to the many sacrifices needed to sustain a man in the practice of medicine and in the collateral activities of organized medicine. His associates in medical practice have graciously

C. A. Hoffman, M. D.

assumed many additional chores caused by his frequent absence from office and hospital.

He has good business sense and judgment, attributes not possessed by the average physician. This ability was first in evidence, when, at the age of 13, as an orphaned child, he was employed as an errand boy in a drug store in Ironton, Ohio. Later, he went deeply in debt to purchase this same business and applied the net returns therefrom to finance his college and medical education.

He entered the practice of urology in 1940, and from that time on demonstrated the qualities of leadership. To cite just a few—he has been president of the YMCA, the Rotary Club, the Chamber of Commerce and the Guyan Country Club. By the way his presidency of the latter organization was not in recognition as a golfer—he is rather much of a hacker and barely manages beating his wife on their occasional nine-hole bouts.

In the field of organized medicine he has been president of his local society; delegate, councilor and President of the State Medical Association, and as Chairman of its Insurance Committee did much to develop an outstanding insurance program for the physicians in this State—in fact, he has national recognition as an authority in this economic field. He is a member of the Medical Licensing Board of West Virginia, a member of the Health Advisory Committee to the Appalachian Regional Commission, a Delegate to the American Medical Association and a member of its very important Council on Medical Service. He is Secretary of the National Association of Blue Shield Plans and has served as Treasurer of the American Urological Association for several years.

Lest any reader get the impression that our subject is a consummate paragon of virtue, please be advised that he is subject to all the frailties and vices which plague all mankind. His greatest fault lies in his acceptance of too many responsibilities with all the related mental and physical stress and strain. His family and friends are at times concerned with the possibility that he carries too many concurrent responsibilities in the activities of organized medicine, but to date he has functioned with an air of competence sustained by the qualities of leadership. His ability to accomplish these varied commitments with elan and dispatch is of no surprise to those who know his background and are aware of his natural talents.

On Thursday, June 1, our subject was installed as President of the American Urological Association—an honor never before held by a West Virginian. His many friends and colleagues salute him and wish for him every success during his presidency. Perhaps the ultimate in the recognition of his qualities of leadership has not yet been reached. Who knows what further recognition lies just beyond the horizon?

In case you have not as yet identified the subject of this editorial, he was christened Charles Anthony Hoffman, better known as "Carl" to friends and associates.—JSK.

THE TOBACCO PROBLEM

The following quotes have been collected from the Winter Edition of *Medical Bulletin on Tobacco*:

"A highly marked association of intermittent claudication and a history of cigarette smoking was demonstrated in the histories of 100 patients suffering from this condition—96 were current smokers and 77 were in a "moderate classification. Three ex-smokers had given up the habit for 18 to 23 years before the onset of claudication, only one of the 100 was a non-smoker."

From a Soviet paper—"Tobacco smoking is one of the main factors predisposing the vascular wall to intensive development of the arteriosclerotic process."

In a resolution of the American Cancer Society—"The physician should recognize the importance of his attitude and action as a non-smoker in setting an example."

"The Federal Trade Commission on March 28, 1966 rescinded its restriction which banned the listing of nicotine and tar content in cigarettes on packaging and in advertising."

"Complete cessation of smoking appears to be the only effective therapy for the patient with Buerger's disease. Simple reduction in the amount of tobacco consumed in any form or the use of denicotinized cigarettes offers no measurable benefits."

"An analysis of total death rates and mortality for various disease associated with smoking in a 6-year study of 441,542 men and 568,797 women confirms the previous findings in differences between male smokers and non-smokers and discloses for the first time in a study of this magnitude similar though less severe relationship for women smokers and non-smokers."

Elsewhere in this issue of *The Journal* may be found an article dealing with the growth of the West Virginia University Medical Center Library.

THE MEDICAL CENTER LIBRARY

It is gratifying that the School of Medicine, and indeed, the entire Medical Center has such a splendid library. The former two-year School of Medicine had a small but fairly adequate library. Although most of the books and periodicals had to do with the basic sciences, a substantial number of clinical journals and monographs had been acquired throughout the years.

The Medical Center Library presently contains approximately 75,000 volumes and receives about 1,517 periodicals annually. The library is well staffed and has a fairly adequate budget.

The article stresses the importance of the location of a medical library. Ideally, it should be placed in the center of the medical complex. If this cannot be done, it should be located as centrally and conveniently as practicable. In essence, every effort should be made to have the library quickly accessible to as many people as possible. The more centrally and the more conveniently it is placed the more it will be used. The Medical Center Library although not centrally placed is nevertheless located conveniently and strategically for its many users.

The library offers a helpful service to the medical profession of the State. If, for example, a physician wishes to procure an article in a journal, the library will promptly send a Xerox copy of the article at a nominal cost. This is much more satisfactory than sending a bound volume through the mails. It is hardly necessary to state that the library is always open to physicians and the library staff is quite willing to help in any way possible.

The importance of an adequate library is so generally appreciated that there is no need to belabor the point. It is in order, however, to quote the opinion of two famous scholars: a physician interested in medical libraries, and an English professor interested in libraries in general. Sir William Osler in one of his brilliant aphorisms writes, "To study the phenomena of disease without books is to sail uncharted seas . . ." One is also reminded of the incident related about George Lyman Kittredge of Harvard University. When he was asked for comments on the huge Widener Library which was to be constructed in Harvard Yard, and which would actually dwarf the other famous old buildings, he is reputed to have said, "I'll take it, I'll take it for all its bulk, because if every building in the Yard were to burn down, you'd still have a university."

ETHICS

It is unethical for a physician to be influenced in the prescribing of drugs or devices by his direct or indirect financial interest in a pharmaceutical firm or other supplier. It is immaterial whether the firm manufactures or packages the products involved.

It is unethical for a physician to own stock or have a direct or indirect financial interest in a firm that uses its relationship with physician-stockholders as a means of inducing or influencing them to prescribe the firm's products. Practicing physicians should divest themselves of any financial interest in firms that use this form of sales promotion. Reputable firms rely upon quality and efficacy to sell their products under competitive circumstances, and not upon appeal of physicians with financial involvements which might influence them in their prescribing.

Prescribing for patients involves more than the designation of drugs or devices which are most likely to prove efficacious in the treatment of a patient. The physician has an ethical responsibility to assure that high quality products will be dispensed to his patient. Obviously, the benefits of the physician's skill are diminished if the patient receives drugs or devices of inferior quality.

Inasmuch as the physician should also be mindful of the cost to his patients of drugs or devices he prescribes, he may properly discuss with patients both quality and cost.—*Adopted by the Judicial Council, American Medical Association, March 12, 1967.*

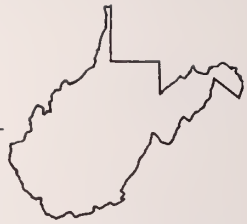
Canadians Link Smoking to Lung Cancer

The heavy smoker—20 or more cigarettes a day—stands a nearly 54 per cent better chance of shortening his life expectancy by 10 or more years than his nonsmoking coeval. This conclusion, among others, is contained in "A Canadian Study of Smoking and Health", based on 92,000 responses, and which took over eight years to complete.

Some of the other observations contained in the report are: that the lung cancer death rate for cigarette smokers is 1400 per cent higher than for nonsmokers; and that the respiratory disease death rate is 700 per cent higher. The coronary heart disease mortality rate for smokers is 87 per cent higher than for nonsmokers.

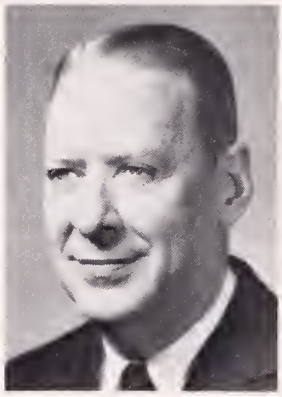
The report also notes, that the mortality rate for cigar and pipe smokers is not appreciably different than for nonsmokers. However, there seems to be a correlation between cigarette smoking and urban dwellers—five or more years city dwelling—is 12 per cent higher than that of rural dwellers of comparable smoking habits.

GENERAL NEWS



Program Completed for Annual Meeting At The Greenbrier, Aug. 24-26

The scientific program has been completed for the 100th Annual Meeting of the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 24-26, 1967.



Dana L. Farnsworth, M. D.

Dr. Ray S. Greco of Weirton, Chairman of the Program Committee, announced that five prominent out-of-state physicians and surgeons will be the speakers at the first two general scientific sessions on Thursday and Friday mornings, August 24-25. The program for the third scientific session on Saturday morning, has been designated "Van Liere-University Day" and will feature as the participants the deans of seven medical schools.

Dr. Farnsworth Native of West Virginia

Dr. Dana L. Farnsworth, a native West Virginian who has risen to prominence in the medical profession, has accepted an invitation to appear as a guest speaker at the second general scientific session on Friday morning, August 25.

Doctor Farnsworth, who is Henry K. Oliver Professor of Hygiene and Director of University Health Service at Harvard University, was born in Troy, Gilmer County. He attended Glenville State Teacher's College and was graduated from West Virginia University.

After working two years in West Virginia as a high school teacher, he entered medical school and in 1933 received his M. D. degree from Harvard Medical College. He interned at Massachusetts General Hospital and from 1935 to 1941, he was Assistant Director of Health at Williams College.

During World War II he served for five years with the Medical Corps of the United States Navy and was discharged with the rank of Commander. Following the war, he returned to Williams College as Director of Health and one year later he accepted the position as Medical Director of the Massachusetts Institute of Technology. He served as acting dean of students at MIT, 1950-51. He was appointed to his present position at Harvard in September, 1954.

He is a Diplomate of the American Board of Psychiatry and Neurology and a Fellow of the American Psychiatric Association in which he was a member of the Council, 1958-61.

He is a member of the American Medical Association and is currently serving as Chairman of the AMA Council on Mental Health. He has been the recipient of honorary degrees from six colleges and universities and he served as President of the American College of Health, 1953-54.

Doctor Farnsworth has written numerous articles on medical and educational subjects for various journals and is the author or co-author of six books.

First General Session

Elsewhere in this issue of *The Journal* is an article concerning the appearance of Dr. William B. Walsh as an honor guest at the Centennial Meeting. Doctor Walsh, who founded Project HOPE, will be the first speaker at the opening general scientific session on Thursday morning, August 24. Other speakers that morning will be as follows:

Brian Blades, M. D., Lewis Saltz Professor of Surgery and Chairman, Department of Surgery, George Washington University School of Medicine, Washington, D. C.

John C. Ullery, M. D., Professor and Chairman, Department of Obstetrics and Gynecology, Ohio State University College of Medicine, Columbus.

Second General Session

The speakers at the second general session on Friday morning will be as follows:

Charles A. Doan, M. D., Dean Emeritus, Ohio State University College of Medicine, Columbus.

John K. Lattimer, M. D., Professor of Urology, College of Physicians and Surgeons of Columbia University, New York City.

Dana L. Farnsworth, M. D., Henry K. Oliver Professor of Hygiene and Director of University Health Services, Harvard University.

Time will be allotted for questions and answers following the presentation of each paper.

Afternoon Meetings

Meetings of all sections and affiliated societies will be held on Friday afternoon, August 25, with the exception of the West Virginia State Society of Allergy. The meeting of the Allergy Society will be held on

Thursday afternoon following the conclusion of the special program on "Medicine and Religion."

All of the guest speakers have been extended an invitation to present papers at the afternoon meetings.

Drs. Rouse and Gresham Honor Guests

Dr. Milford O. Rouse of Dallas, Texas, President of the American Medical Association, will be among the honor guests and will be an active participant in the meeting. He will deliver an address at the first session of the House of Delegates on Wednesday afternoon, August 23, the day preceeding the formal opening of the meeting.

Doctor Rouse also will be the physician representative on the program devoted to "Medicine and Religion" which will be held on Thursday afternoon, August 24.

Dr. Perry E. Gresham, President of Bethany College, will be the speaker at the Centennial Banquet which will be held on Friday evening.

Business Sessions

The pre-convention meeting of the Council will be held on Wednesday morning, August 23. The first session of the House of Delegates will be held that afternoon.

Dr. Richard E. Flood of Weirton, the President, will deliver his Presidential Address at the second and final session of the House of Delegates on Saturday afternoon, August 26. Officers for the coming year also will be installed at that time.

Entertainment Features

The entertainment program for the Annual Meeting is under the direction of the Woman's Auxiliary. There will be a dance on Thursday night and the Centennial Banquet and Ball has been arranged for Friday night. A reception honoring officers of the State Medical Association will be held on Saturday evening.

Room Reservations Pass 500 Mark

The number of room reservations at The Greenbrier for the Annual Meeting in August has passed the 500 mark and it is anticipated that more than 800 persons, including physicians, their wives and guests will be in attendance. All physicians who plan to attend the meeting are urged to make reservations as soon as possible. An early request will assure physicians, their families and guests of room accommodations.

The complete program for the Annual Meeting will be published in the August issue of *The Journal.*

Superintendent Needed at Denmar

The State Commissioner of Public Institutions is interested in obtaining a physician to serve as Superintendent of Denmar State Hospital. The 210-bed hospital has been utilized as a hospital for "chronically ill" patients since 1957.

There appears elsewhere in this issue of *The Journal* (page xxxii) a letter from Commissioner Chauncey H. Browning, Jr., outlining in detail the responsibilities of the position.

No Convention Registration Fee

No registration fee will be assessed against either members or guests in connection with the 100th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 24-26, 1967.

A cordial invitation to attend all sessions has been extended by the Program Committee to interns and physicians serving in hospitals in West Virginia and adjacent states.

Requests for hotel accommodations should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs.

Journalism Award Winners Announced by AMA

The American Medical Association has announced the winners in its $5,000 medical journalism awards contest for 1966.

First place winners in each of the five categories of the contest are:

Newspapers: Jerry Bishop, William Carley, Richard James and Jonathan Spivak, all of *The Wall Street Journal,* for several articles each on medicine and health.

Magazines: Steven M. Spencer, for an article in *The Saturday Evening Post* entitled "The Birth Control Revolution."

Editorial Writing: WXYZ-TV, Detroit, for a series of editorials on measles immunization.

Radio: KNX-CBS, Los Angeles, for a program on "The Battered Child."

Television: The National Broadcasting Company, for a program, "The Air of Disaster."

First place in each category carries a cash award of $1,000 and a plaque for "an outstanding example of journalism that contributes to a better public understanding of medicine and health in the United States."

Hospital in Wheeling Seeks Issues of Journal

The Medical Library of Ohio Valley General Hospital in Wheeling is seeking certain back issues of *The West Virginia Medical Journal* in order to complete its file.

The Library needs the following back numbers: All issues for the years 1915, 1917, 1918, and 1919; all issues for 1916 except July, August, October, and November; all issues for 1920 except April, May, June, and July; and all issues for 1921 except January and February.

Any physician who has one or more of the missing issues and who would like to donate it to the hospital is asked to contact the Medical Library, Ohio Valley General Hospital, Wheeling, West Virginia 26003.

Van Liere - University Day Program

As a special feature of the 100th Annual Meeting of the West Virginia State Medical Association, a "Van Liere—University Day" program has been arranged to honor Dr. Edward J. Van Liere, retired Dean of the West Virginia University School of Medicine. The program on Saturday morning, August 26, will have as its theme "Medical Education — Past, Current and Future." Participating will be the Deans of seven medical schools with whom Doctor Van Liere has been associated for many years. *(See opposite page).*

Edward J. Van Liere, M. D., Ph. D.
Dean Emeritus, WVU School of Medicine

Edward J. Van Liere, M. D., Ph. D., was born in Kenosha, Wisconsin, on October 30, 1896. He attended the University of Wisconsin, where he earned the degrees of Bachelor of Arts and Master of Science. He entered the Harvard Medical School, where he received his Doctor of Medicine degree in 1920. Doctor Van Liere also was awarded a Doctor of Philosophy degree by the University of Chicago.

Doctor Van Liere joined the faculty of the old two-year West Virginia University School of Medicine in 1921. He was promoted to Dean in 1935, a position from which he retired in 1961. During the later years of his stewardship, Dean Van Liere was instrumental in the development of the old two-year school into a four-year curriculum and the establishment of the modern multi-million-dollar Medical Center, of which the Medical School is an integral part.

One year ago, upon reaching the age of 70, Doctor Van Liere was retired from the active academic rolls of the University. He retired with the titles of Dean Emeritus, Professor of Physiology and Research Professor of Obstetrics.

During his long, distinguished career at WVU, Doctor Van Liere developed an affinity for teaching and writing. He participated in and supervised the training of more than 2,000 medical students. His prolific pen produced for both scientific and lay literature hundreds of articles and a half-dozen books. He has written scores of editorials for *The West Virginia Medical Journal,* of which he has served as Associate Editor for many years.

To this distinguished gentleman, citizen and physician, the West Virginia State Medical Association will pay tribute at its 100th Anniversary Meeting.

PROGRAM PARTICIPANTS

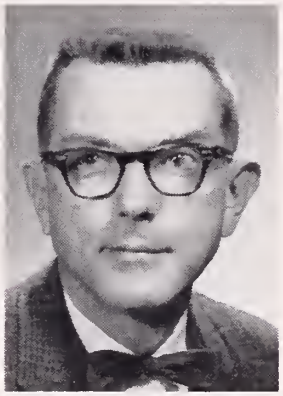
Clark K. Sleeth, M. D., Dean,
WVU School of Medicine
Moderator

William A. Sodeman, M. D., Dean Emeritus,
Jefferson Medical College
Philadelphia

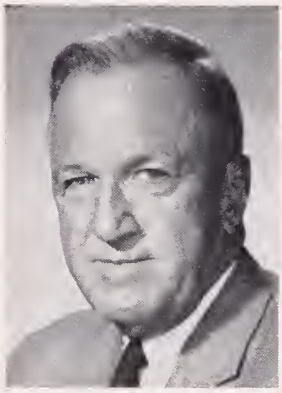
William S. Stone, M. D., Dean,
Univ. of Maryland School of Medicine
Baltimore

John Parks, M. D., Dean,
George Washington Univ. School of Medicine
Washington

Kinloch Nelson, M. D., Dean,
Medical College of Virginia
Richmond



Kenneth R. Crispell, M. D., Dean,
Univ. of Virginia School of Medicine
Charlottesville

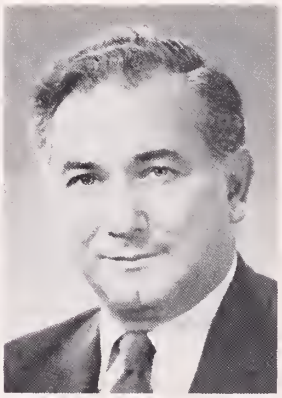


Charles A. Doan, M. D., Dean Emeritus,
OSU School of Medicine
Columbus

W. Va. Allergy Society Plans Meeting At The Greenbrier on Aug. 24

Seven prominent physicians have accepted invitations to appear as speakers at the 10th annual meeting of the West Virginia State Society of Allergy which will be held at The Greenbrier in White Sulphur Springs on August 24. The 10th anniversary meeting of the Society will be held in conjunction with the 100th Annual Meeting of the West Virginia State Medical Association.

A. Harvey Neidorff, M. D.



Howard G. Rapaport, M. D.

The Society was organized for the purpose of furthering the practice of allergy in West Virginia and to provide increased education in the specialty in the State. The Society was accepted as an affiliated Society of the West Virginia State Medical Association in 1957 The Society also has been recognized by the American Academy of Allergy and the American College of Allergists.

The Committee arranging the program has decided to depart from the usual custom of having two speakers and instead present a round table of distinguished allergists from throughout the United States. Each of the speakers will present a brief formal presentation of his subject and the remainder of the session will be devoted to questions and answers.

Dr. Merle S. Scherr of Charleston will serve as moderator for the panel discussion and the other participants and their subjects will be as follows:

Dr. Howard G. Rapaport of New York City, President of the American College of Allergists, who will bring greetings from the College as well as discuss "Practical Allergy in General Medicine Today."

Dr. Bernard Berman, Brookline, Massachusetts—"Advances in Pediatric Allergy."

Dr. Philip Blank, Pittsburgh—"Urticaria, Migraine, Insect and Miscellaneous Allergies."

Dr. Irvin Caplin, Indianapolis, Indiana—"Bronchial Asthma and Its Management."

Dr. Joseph H. Fries, New Hyde Park, New York—"Management of Food Allergy."

Dr. Mayer A. Green, Pittsburgh—"Nasal Allergy and Its Management."

Dr. A. Harvey Neidorff, Altoona, Pennsylvania—"Allergic Contact and Atopic Dermatitis."

The program for the Allergy Society will be supported in part by a grant-in-aid from Center Laboratories of Port Washington, New York.

The meeting of the West Virginia State Society of Allergy will begin at 3:30 P. M. on August 24, immediately upon conclusion of a special program which has been arranged on "Medicine and Religion" in connection with the Centennial observance of the State Medical Association.

Officers of the Allergy Society are: Dr. Robert H. Mutch of Fairmont, President; Dr. W. L. Neal of Huntington, Vice President; and Dr. Merle S. Scherr of Charleston, Secretary-Treasurer.

West Virginia Teenager Wins AMA Science Citation

A 17-year-old Morgantown girl won one of the eight "Award of Merit" citations presented by the American Medical Association at the 18th International Science Fair in San Francisco in May.

She is Miss Sharon Allee Bloor, a high school junior. She received the honor for her study of "Chromosome Diagnosis of Marfan's Syndrome (Lincoln's Disease)."

A committee comprised of members of the AMA Council on Scientific Assembly selected Miss Bloor and the other winners for AMA recognition. She received the citation at a Health Awards Banquet on May 11 from Dr. Dwight L. Wilbur, a member of the AMA Board of Trustees.

Miss Bloor entered the international competition as a finalist from the Salem College Regional Science Fair.

Acad. of Orthopaedic Surgeons Slates PG Course

The American Academy of Orthopaedic Surgeons will sponsor a postgraduate course in sports medicine in Oklahoma City, August 14-16.

Invited to attend the three days of lectures and demonstrations are orthopedic surgeons, general physicians, high school and college team physicians and others with a medical interest in the care of the athlete.

Chairman of the course is Dr. Don H. O'Donoghue, Chairman of the Department of Orthopaedic Surgery at the University of Oklahoma School of Medicine.

Additional information may be obtained by writing to the American Academy of Orthopaedic Surgeons, 29 East Madison Street, Chicago, Illinois 60602.

Bluefield Sanitarium Seminar

The annual Seminar sponsored by the Bluefield Sanitarium will be held at the Bluefield Country Club on October 12. The Seminar is sponsored jointly by the Bluefield Sanitarium, Stevens Clinic Hospital in Welch and the Clinch Valley Clinic in Richlands, Virginia.

Further information concerning the program will appear in future issues of *The Journal.*

Dr. William B. Walsh Honor Guest At Centennial Meeting

Dr. William B. Walsh of Washington, D. C., the Founder, President and Medical Director of Project HOPE, will be among the honor guests at the 100th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 24-26.

Dr. Ray S. Greco of Weirton, Chairman of the Program Committee, announced that Doctor Walsh had accepted an invitation to appear as a guest speaker at the first general session on Thursday morning, August 24. Members of the Auxiliary and other guests have been extended a cordial invitation to hear the address by Doctor Walsh.

A native of Brooklyn, New York, Doctor Walsh was graduated from St. John's University and received his M. D. degree in 1943 from the Georgetown University School of Medicine. He interned at Long Island College Hospital and served a residency at Georgetown University Hospital.

During World War II, he served as medical officer aboard a destroyer in the South Pacific. According to Doctor Walsh, the squalor and poor hospital conditions of the area began the young physician's dream of returning with a floating medical school.

When, in 1958, President Eisenhower asked Doctor Walsh to co-chair the Committee on Medicine and the Health Professions of the President's new People-to-People Program, Doctor Walsh suggested that a Navy hospital ship be taken out of mothballs and converted into a floating medical center.

After he won approval of the idea, Doctor Walsh decided that its success hinged on support from private American citizens, and he founded the People-to-People Health Foundation, Inc., the parent organization of Project HOPE, which sponsors the world-wide voyages of the hospital ship S. S. HOPE.

At the time, Doctor Walsh was a prominent internist and heart specialist and an assistant professor of internal medicine at Georgetown University. To devote full time to his duties as medical director and president of Project HOPE, he has given up his private practice. In 1965 Doctor Walsh was named by President Johnson as chairman of Project Viet Nam, a cooperative medical effort of America's intervoluntary agencies for the people of South Viet Nam.

Doctor Walsh has received honors and awards from all over the world and he is the author of two books, "A Ship Called Hope," an account of the S. S. HOPE'S maiden voyage to Asia, and "Yanqui, Come Back!", the story of HOPE in Peru.

Dr. William B. Walsh, Founder of Project HOPE, is shown with several Nicaraguan children aboard the S. S. HOPE in Corinto.

Education and Alumni Day Program

Charleston Memorial Hospital conducted its annual Education and Alumni Day Program in Charleston on Friday, June 23.

Drs. Kenneth G. MacDonald and Daniel Hamaty, both of Charleston, served as moderators for the scientific sessions. The program also featured a panel discussion of the inter-relations of medical education and medical practice.

Medical Writers Association Meeting in Chicago

The 27th Annual Meeting of the American Medical Writers' Association (AMWA) will be held at the Palmer House in Chicago, September 21-24.

The program is designed for both physicians and journalists with interest in the field of medical writing. Attendance is open to both members and nonmembers of AMWA.

A major feature of the meeting is a workshop in which manuscripts submitted in advance are critically reviewed by panels of editors. Among special sessions this year will be discussions of educating medical writers, ethics in medical journalism, new methods of approaching the literature, drug information as viewed by government, industry and the journals, and medical news for the physician.

Further information may be obtained from AMWA, Post Office Box 267, Arlington, Virginia 22210.

Spring Meeting of The Council In Charleston on May 21

The Spring meeting of the Council was held at the Daniel Boone Hotel in Charleston on Sunday, May 21, 1967, with the Chairman, Dr. Seigle W. Parks of Charleston, presiding.

There was considerable discussion concerning plans for the Centennial Meeting which will be held at The Greenbrier in August and it was announced that the scientific program had been completed (see articles elsewhere in this issue of *The Journal*).

Doctor Weeks Appointed Member of Council

Doctor Parks reported that Dr. Joseph L. Curry of Wheeling, a Councilor from the first district, had submitted his resignation due to the fact he planned to relocate his practice in another state during the summer.

Dr. Richard E. Flood, the President, announced that he had appointed Dr. Harry S. Weeks, Jr., of Wheeling, to fill the unexpired term of Doctor Curry.

1967-68 Nominating Committee

The following physicians were elected to serve as members of the Nominating Committee during the Annual Meeting at The Greenbrier:

Dr. G. Thomas Evans of Fairmont (1st district); Dr. Maynard P. Pride of Morgantown (2nd district); Dr. Andrew J. Weaver of Clarksburg (3rd district); Dr. I. Ewen Taylor of Huntington (4th district); Dr. A. J. Villani of Welch (5th district); and Dr. W. P. Bittinger of Oak Hill (6th district).

Dr. Albert C. Esposito of Huntington, the Junior Councilor-at-Large, automatically will serve as Chairman of the Committee which will recommend its nominees to serve as officers of the Association during 1967-68.

Doctor Parks announced that the West Virginia Pediatric Society and the West Virginia Chapter, American Academy of Pediatrics, had merged and had requested that the group be designated as the Section on Pediatrics of the West Virginia State Medical Association. The request was approved by the Council.

Election of Honorary Members

The following physicians were elected to honorary life-membership in the West Virginia State Medical Association:

Physician	*Address*	*Society*
L. Rush Lambert	Barrackville	Marion
E. A. Litsinger	Ripley	Kanawha
Robert M. Sonneborn	Wheeling	Ohio

Appalachian Regional Development Act

Dr. James S. Klumpp presented a detailed report concerning recent efforts to implement the Appalachian Regional Development Act of 1965. He reported the State Medical Association had called a conference in Washington on March 10 which was attended by representatives of 9 of the 12 Appalachia state medical societies.

Following considerable discussion, the Council unanimously approved the following resolution and directed that it be submitted for consideration by the House of Delegates of the American Medical Association during the Annual Convention in June.

Whereas, The Appalachian Regional Development Act was enacted in 1965 and one of the concerns in this Act was the improvement of health conditions and conservation of health resources in those states, or parts thereof, contained in what is titled Appalachia.

Resolution No. 43, adopted under the provisions of this Act, established a Health Advisory Committee with two members from each state in Appalachia, one appointed by each respective Governor, and twelve members thereof appointed by the Federal Co-Chairman of the Appalachia Regional Commission. The original Advisory Committee numbered but one physician from the private sector of medicine as a member. As a result of protest by organized medicine in the Appalachian states, there are now four private practitioners on this committee.

The Health Advisory Committee prepared Resolution No. 62, proposed as guidelines for the implementation and operation of regional health services facilities, which was adopted verbatim by the Commission, and as such has the full effect of law. In the opinion of many medical men, these guidelines contain ambiguous connotations and are subject to a variable degree of interpretation by present or future individuals or groups who might have administrative authority under the provisions of the Act.

Therefore Be It Resolved, By the House of Delegates of the American Medical Association, that said Asociation shall withhold blanket or general approval of the provisions and regulations contained in the ARD Act of 1965 which pertain to matters of public health, but rather shall advise the state medical associations in Appalachia, and the component medical societies therein, to consider and approve or disapprove the implementation of regional health services facilities and other proposals which arise under the provisions of the ARD Act of 1965, as local or regional matters. Approval of these projects should be contingent upon acceptance and maintenance of the following conditions by pertinent federal, state and local authorities in the implementation of said Act:

(1) The operation of any regional, area or county health service facility shall not infringe upon the private practice of medicine.

(2) All health services, whether preventive, prophylactic or therapeutic, shall be rendered at a cost commensurate with the social and economic status of the patient.

(3) There shall be adequate medical representation on all national, state and local bodies having supervision or jurisdiction in the development and/or operation of such health service facilities.

(4) These health service projects shall in no way be developed, operated or influenced in any manner which could lead to a government-controlled system of medical practice.

Definition of Medical Indigency

Dr. George R. Callender, Jr., reported that in 1966 the House of Delegates of the American Medical Association adopted a report of the Council on Medical Service pertaining to the "Definition of Medical Indigency" and the "Principles for the Determination of Medical Indigency." Doctor Callender recommended that the Council also go on record as approving the

report of the Council on Medical Service. The recommendations were unanimously approved.

The following members of the Council were present: Dr. Seigle W. Parks, of Charleston, Chairman; Dr. Richard E. Flood of Weirton, President; Dr. Richard V. Lynch, Jr. of Clarksburg, President Elect; Dr. Richard W. Corbitt of Parkersburg, Vice President; Dr. Kenneth G. MacDonald of Charleston, Treasurer; Drs. G. Thomas Evans of Fairmont; Maynard P. Pride of Morgantown; S. Elizabeth McFetridge of Shepherdstown; Andrew J. Weaver of Clarksburg; I. Ewen Taylor of Huntington; A. J. Villani of Welch; W. P. Bittinger of Oak Hill; George R. Callender, Jr., of Charleston; and Mr. William H. Lively, Secretary ex officio and Mr. Edward Hagan, Executive Assistant.

The meeting was also attended by Dr. Frank J. Holroyd of Princeton; AMA Delegate; Dr. C. A. Hoffman of Huntington, AMA Delegate; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. James S. Klumpp of Huntington, Parliamentarian; Dr. N. H. Dyer of Charleston, Director of the State Department of Health; Dr. L. J. Pace; Mrs. Wilson P. Smith, Immediate Past President of the Woman's Auxiliary; and Mr. Jim Imboden, AMPAC representative.

State Health Department Urges Better TB Reporting

One hundred thirty-five cases of tuberculosis were reported in West Virginia during the month of April, State Health Director N. H. Dyer said recently in an issue of the "State of the State's Health."

"Our state already ranks 15th in incidence of tuberculosis and fourth in the number of deaths in the nation," the health official said. "If the increase in newly reported cases continues, the total for 1967 could very well reach the figure of 1,500 cases—ranking West Virginia much higher among the states in incidence," he remarked.

Doctor Dyer noted that six of the cases were discovered in one family in Nicholas County. He said 42 new cases were reported for the week ending April 22. Of this number, 25 were reported from Kanawha County as a result of a skin testing program in one of the high schools. Reports for the week ending April 29 showed nine additional cases in Kanawha County as a result of a skin testing program in one of the high schools. Reports for the week ending April 29 showed nine additional cases in Kanawha County as a result of further skin testing and x-ray examination. Nine of the cases reported in April were in Fayette County.

One of the weakest points in the control of tuberculosis in West Virginia, Doctor explained, is the failure of physicians, hospitals, and other sources to report the cases of tuberculosis as they are diagnosed. Of the 544 newly reported active cases of tuberculosis last year, 21 were reported for the first time on death certificates, which would indicate that either casefinding, or reporting, or both, were not good, he said.

Doctor Dyer said, "The control of tuberculosis is deterred in many of the counties by the failure of the local health officer to ask the prosecuting attorney to petition the court for an order to commit a person to a tuberculosis sanatorium when evidence of active TB is present."

In the future, Doctor Dyer pointed out, grants from the U.S. Public Health Service may be available to the states for:

A. Service to unhospitalized active cases, inactive cases for five years after the disease becomes inactive, and contacts of new active cases.

B. Identification of persons at risk through (1) tuberculin testing of children entering school and examination of reactors' associates; (2) examination of school teachers and employees, and (3) routine hospital admission x-rays in public hospitals in cities of over 250,000. (We have no cities of this size, however, some of the larger hospitals in the state do hospital admission x-rays.)

C. Continuing periodic examination of persons at risk and prophylactic treatment when indicated.

West Virginia has requested $210,863 for fiscal year 1967 from the U.S. Public Health Service, $232,351 for fiscal year 1968, and $250,000 for fiscal year 1969. These amounts may be adjusted as the need arises in the activities of the program, Doctor Dyer pointed out.

Doctor Dyer reported that the special tuberculosis project begun in 1961 has now extended into 44 counties. Since the project started, a total of 1,126 diagnostic clinics, with chest specialists have been held. A total of 15,442 patients have been seen in these clinics, of which 4,949 were on active registers, 2,282 were contacts to active cases, 4,627 were suspects for tuberculosis and 3,359 were on inactive registers and due for examination. During this period, 324 patients entered sanatoriums and 2,233 were placed on drug therapy. Approximately 3,000 new cases of tuberculosis have been reported from the project counties since its beginning.

As a part of the regular casefinding program of the Bureau of Tuberculosis Control, two mobile chest x-ray units visited all counties except Ohio and Marshall which could not accept the service at the time it was scheduled to them. A total of 91,699 x-rays were made, which included 4,614 in state institutions. Of these, 1,388 were suspects for tuberculosis, 264 were tumor suspects, 451 had indications of cardiovascular disease, 1,187 were diagnosed as having chronic lung disease, 160 indicated acute lung conditions, and 317 had other chest abnormalities.

Leukemia Conference in Michigan October 9-13

An International Conference on Leukemia-Lymphoma will be held in Ann Arbor, Michigan, October 9-13.

The meeting will bring together outstanding scientists who are contributing to the advance of knowledge regarding leukemia and the related lymphomas.

Additional information may be obtained by writing to Dr. Chris J. D. Zarafonetis, Director, the Thomas Henry Simpson Memorial Institute, University of Michigan, Ann Arbor, Michigan 48104.

New Association Members

Dr. David R. Hess, 101 East Main Street, Bridgeport (Harrison). Doctor Hess, a native of Bridgeport, was graduated from West Virginia University in 1961 and received his M. D. degree from the WVU School of Medicine in 1965. He interned at Charleston Memorial Hospital, 1965-66. He served with the United States Air Force and he is engaged in general practice.

* * * *

Dr. Murry B. Hunter, Fairmont Clinic, Fairmont (Marion). Doctor Hunter, a native of Brooklyn, New York, was graduated from the University of Iowa. He received his M. D. degree from Duke University School of Medicine in 1950 and interned and served a residency at Duke. Doctor Hunter served with the United States Army Infantry, 1943-45, and his specialty is internal medicine.

* * * *

Dr. Reverdy H. Jones, Jr., Fairmont Clinic, Fairmont (Marion). Doctor Jones, a native of Portsmouth, Virginia, was graduated from Virginia Military Institute in 1934 and received his M. D. degree from the University of Virginia School of Medicine in 1938. He interned at Lankenau Hospital in Philadelphia, 1938-40, and served a fellowship in internal medicine at the Mayo Clinic, 1940-41. He received an M. S. degree in medicine from the University of Minnesota, 1946-48. Doctor Jones served with the United States Navy, 1941-46, and his specialty is internal medicine.

* * * *

Dr. Victor E. Mazzocco, 25 Brooks Medical Building, Charleston (Kanawha). Doctor Mazzocco, a native of Morgantown, was graduated from West Virginia University in 1957 and received his M. D. degree from the Medical College of Virginia in 1961. He interned at Charleston Memorial Hospital, 1961-62, and served a residency at the WVU Hospital, 1962-66. He served with the U. S. Navy, 1951-56, and his specialty is internal medicine.

* * * *

Dr. Frederick A. Spencer, 48 Carolina Avenue, Salem, (Harrison). Doctor Spencer, a native of Middletown, Connecticut, was graduated from Salem College and received his M. D. degree from the University of Arkansas School of Medicine in 1961. He interned at the U. S. Navy Hospital in Pensacola, Florida, 1961-62. He did postgraduate at the U. S. Navy School of Aviation Medicine, Pensacola. He served with the U. S. Navy MC from June 1961 to December 1966. His specialty is surgery.

* * * *

Dr. D. C. Trapp, Wheeling Clinic, Wheeling (Ohio). Doctor Trapp, a native of Pittsburgh, was graduated from the University of Pittsburgh in 1950 and received his M. D. degree in 1955 from Temple Medical School. He interned at Presbyterian University Hospital in Pittsburgh in 1959 and at the USVAH in Pittsburgh, 1962-66. He served with the Medical Corps of the United States Navy, 1956-58, and his specialty is urology.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1967

July 14-15—Rocky Mtn. Cancer Conf., Denver.
July 23-29—Sou. Seminar in Ob. & Gyn., Asheville, N. C.
Aug. 21-24—Am. Hosp. Assn., Chicago.
Aug. 24-26—100th Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.
Aug. 27-Sept. 1—Am. Acad. of Phys. Med. & Rehab., Miami Beach.
Sept. 7-9—Am. Assn. of Ob. and Gyn., Hot Springs, Va.
Sept. 15-23—AAGP, Dallas.
Sept. 22-29—Col. of Am. Pathologists, Chicago.
Sept. 26-28—Ky. Medical, Louisville.
Sept. 27-30—Penn. Medical, Philadelphia.
Sept. 29-Oct. 1—W. Va. Heart Assn., Wheeling.
Sept. 29-Oct. 3—Am. Soc. of Anes., Las Vegas.
Oct. 2-6—ACS, Chicago.
Oct. 5—Rural Health Conf., Jackson's Mill.
Oct. 5-7—Assn. of Am. Phys. & Sur., Houston.
Oct. 12—Bluefield Sanitarium Seminar, Bluefield.
Oct. 19-21—Va. Medical, Alexandria.
Oct. 20-24—Am. Heart Assn., San Francisco.
Oct. 21-26—Am. Acad. of Ped., Washington.
Oct. 25-28—Cong. of Neurological Sur., San Francisco.
Oct. 29—Am. Assn. of Oph., Chicago.
Oct. 29-Nov. 3—Am. Acad. of Oph. and Otol., Chicago.
Nov. 13-16—Southern Medical, Miami Beach.
Nov. 16-19—Nat. Soc. for Crippled Children & Adults, Los Angeles.
Nov. 25-26—Am. Col. of Chest Phys., Houston, Texas.
Nov. 26-29—AMA Clinical Meeting, Houston, Texas.
Nov. 29-Dec. 3—Am. Med. Women's Assn., Atlanta.
Dec. 2-7—Am. Acad. of Dermatology, Chicago.
Dec. 4-6—Sou. Surgical Assn., Hot Springs, Va.

1968

Jan. 17-18—Am. Rheumatism Assn., Baltimore.
Jan. 20-25—Am. Acad. of Orthopaedic Surgeons, Chicago.
Jan. 29-31—Soc. of Thoracic Sur., New Orleans.
Feb. 3-7—Am. Acad. of Allergy, Boston.
Feb. 6-10—Am. Col. of Radiology, Chicago.
Feb. 28-March 3—Am. Col. of Cardiology, San Francisco.
March 18-20—Am. Acad. of Ped., Atlanta.
March 24-29—Am. Col. of Allergists, Denver.
March 29-31—Am. Soc. of Int. Med., Boston.
April 1-5—ACP, Boston.
April 16-19—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 17-19—Maryland Medical, Baltimore.
April 22-24—Am. Assn. for Thoracic Surg., Pittsburgh.
April 22-25—Am. Col. of Ob. & Gyn., Chicago.
April 25-26—Am. Hosp. Assn., Hollywood, Fla.
May 1-2—Am. Ped. Soc., Atlantic City.
May 7-8—Assn. of Am. Phys., Atlantic City.
May 12-17—Am. Psy. Assn., Boston.
May 13-16—Am. Urological Assn., Miami Beach.
May 14-17—Ohio Medical, Cincinnati.
May 19-22—Nat. TB Assn., Houston.
May 23-25—Am. Gyn. Soc., Hot Springs, Va.
June 15—Acad. of TB Phys., San Francisco.
June 15-16—Am. Diabetes Assn., San Francisco.
June 16-20—Am. Col. of Chest Phys., San Francisco.
June 16-20—Am. Col. of Preventive Med., San Francisco.
June 16-20—AMA, San Francisco.
June 20-22—Am. Med. Women's Assn., San Francisco.
June 26-27—Am. Geriatrics Soc., New Orleans.

MEDICINE AND RELIGION PROGRAM

"The Physician's Dilemma in the World of Changing Attitudes Toward Morals"

A special Medicine and Religion program has been arranged for Thursday afternoon, August 24, as part of the Centennial Meeting of the West Virginia State Medical Association. Three experts on the relationship between the physician and the clergyman in the total care of the patient will participate in a discussion of "The Physician's Dilemma in the World of Changing Attitudes Towards Morals."

The program, beginning at 2:00 P. M., will be moderated by The Rev. Dr. Paul B. McCleave of Chicago, Director of the American Medical Association's Department of Medicine and Religion. Other panelists will be Dr. Milford O. Rouse of Dallas, Texas, President of the American Medical Association; and The Most Rev. Joseph B. Brunini of Jackson, Mississippi, Apostolic Administrator of the Catholic Diocese of Natchez-Jackson.

All physicians, their wives, guests and exhibitors are cordially invited to attend this interesting program.

PARTICIPANTS

The Rev. Dr. Paul B. McCleave
Director, AMA Department of Medicine and Religion
Chicago
Moderator

Milford O. Rouse, M. D., President
American Medical Association
Dallas, Texas

The Most Rev. Joseph Brunini
Apostolic Administrator
Catholic Diocese of Natchez-Jackson
Mississippi

WVU Medical Center
—News—

DR. Richard A. Currie, Associate Professor of Surgery in the School of Medicine, has been awarded a cancer research grant of $51,645.

Richard A. Currie, M. D.

The announcement of the award was made by Dr. David B. Gray of Charleston, President of the West Virginia Division, American Cancer Society. The grant to Doctor Currie brings to more than $292,000 the total amount of grants made by the American Cancer Society to WVU in the last five years.

The objective of Doctor Currie's study is an attempt to experimentally produce primary liver tumors in the monkey. The basis for this experiment is some previous work by Doctor Currie, who has shown that by feeding monkeys a high fat, low choline diet, with and without alcohol, hepatic lesions similar in many ways to human cirrhosis can be produced.

Intern Appointments

Fifty-three new physicians who received their M.D. degrees from the School of Medicine in May will begin their internships on July 1.

Under the National Internship Matching Program, a student is given the opportunity to apply for internships at hospitals of his choice. A computer matches the student with the hospital highest on his list of choices.

Forty-two of the new graduates received their first choice. Fifteen of them will intern in West Virginia hospitals, seven in military hospitals and 31 at institutions in 15 other states.

The names of the new physicians, their home towns and the hospitals where they will intern are as follows:

Jerome C. Arnett, Rowlesburg, Albert Einstein Medical Center, Philadelphia; Darrell C. Belcher, Red Sulphur Springs, Grant Hospital, Columbus, Ohio; Walter B. Bice, Huntington, Cabell-Huntington Hospital; Wilfred S. Boayue, Bunadee, Liberia, Methodist Hospital of Indiana, Indianapolis; James H. Boso, Huntington, Akron City Hospital; and Charles W. Caldwell, Jr., Dunbar, WVU Hospital.

• **Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.**

Lewis V. Campbell, Jr., Gallipolis, Ohio, WVU Hospital; James S. Carter, Bluefield, Akron City Hospital; Martha Haltom Christian, Martinsburg, WVU Hospital; David W. Coghe, Johnstown, Pennsylvania, Norfolk General Hospital; and Jackie L. Collins, Huntington, Hennepin County General Hospital, Minneapolis.

James C. Cosmides, Wheeling, WVU Hospital; Anthony G. DiBartolomeo, Weirton, Walter Reed General Hospital; Jerry A. Dorsch, Wheeling, Wheeling Hospital; George T. Evans, Jr., Fairmont, San Francisco General Hospital; and James O. Fridley, Wardensville, Riverside Hospital, Newport News.

Richard T. Griffey, Prosperity, U. S. Public Health Service, Baltimore; Frank C. Griswold, Beckley. University of Kansas Medical Center, Kansas City; James F. Grow, Jr., Cuyahoga Falls, Ohio, Akron City Hospital; Larry O. Harper, Clendenin, University Hospital, Madison, Wisconsin and Richard L. Hess, Clarksburg, Pontiac General Hospital, Pontiac, Michigan.

George P. Hlusko, Jr., South Charleston, City Hospital at Elmhurst, New York; Nancy J. Jennings, Morgantown, WVU Hospital; Carole A. Kerr, Morgantown, WVU Hospital; Richard S. Kerr, Morgantown, Cabell-Huntington Hospital and Margaret A. Kessinger, Beckley, University of Nebraska Hospital, Omaha.

Albert J. Kolibash, Jr., Benwood, U. S. Naval Hospital, Portsmouth, Virginia; Alan D. Kornblut, Fairfield, Connecticut, Cincinnati General Hospital; and Valeria S. Kullman, Fairmont, St. Joseph Infirmary, Louisville.

Hugo J. McClung, Hartford, University Hospitals, Madison, Wisconsin; Lewis H. McConnell, West Union, Walter Reed General Hospital; and Douglas E. McKinney, Pineville, U. S. Naval Hospital, Charleston, South Carolina.

Paul F. Malone, Grafton, Walter Reed General Hospital; Joseph R. Metz, Eric, Pennsylvania, Walter

(Continued on Page xxvi)

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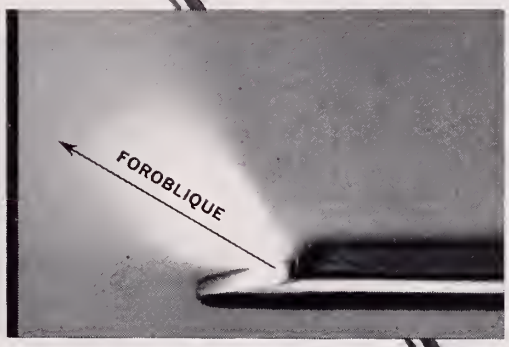

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The Month in Washington

THE Department of Health, Education and Welfare is making a broad study of prescription drugs which will be the basis of a recommendation on whether their costs should be covered by Medicare when they are used outside a hospital.

HEW Secretary John W. Gardner appointed a task force of HEW officials to evaluate the study and make the recommendation.

"Prescription drugs are an essential element of modern medical care," Mr. Gardner said. "In the last twenty-five years we have witnessed greater advances in the use of drugs than in the whole previous history of medicine. Today drugs and biologicals make possible the prevention and successful treatment of illnesses that were serious and frequently fatal.

"Yet for many older Americans the cost of needed drugs prescribed by a physician is a heavy burden, representing 15 to 20 per cent of their medical care costs. Many older Americans find themselves with limited financial resources at the very time that age brings an increasing incidence of chronic disease and greater needs for medical care, including prescription drugs."

President Johnson directed last January that Mr. Gardner "undertake immediately a comprehensive study of the problems of including the cost of prescription drugs under Medicare." Studies on some aspects of the question were started then and are near completion. Other specific studies are in various stages of progress.

But Congress may decide the issue before the full study is completed. The Senate Finance Committee will hold hearings this summer on such a Medicare extension.

Dr. Philip R. Lee, Assistant HEW Secretary and Chairman of the task force, said that even if the study is incomplete, HEW will take a stand anyway when the Senate Finance Committee takes up the legislation.

One bill would finance Medicare coverage of drugs by increasing from $3 to $4 the cost of monthly premiums for the voluntary doctor bills insurance program (Plan B) for persons 65 and over. Sponsored by Sen. Joseph M. Montoya (D., N. M.) the bill would provide that generic drugs rather than trade name products be used whenever possible.

Another bill is sponsored by Chairman Russell B. Long, (D., La.), the Senate's leading critic of the drug industry. It would spur generic purchasing for all federally-connected welfare programs.

• **From the Washington Office of the American Medical Association.**

"The task force will examine a number of factors which are closely involved with the use of prescription drugs and with present and proposed methods of purchasing them," Doctor Lee said. "Many of these factors concern not only drug costs—and who pays them—but also the quality of Medicare care."

Among the major areas listed for task force study:

1. Present patterns of drug prescription by physicians.
2. Present patterns of prescription drug use and expense by patients.
3. Present resources used to meet drug costs (including personal resources, aid from relatives, insurance, government assistance).
4. Present drug cost coverage programs (including federal, state, commercial insurance, union, and foreign programs).
5. Distribution systems (including independent pharmacies, central pharmacies, mail-order distribution, physician dispensing, and hospital dispensing).
6. Reimbursement factors (including determination of costs; co-insurance; deductibles; and limitations on dollar costs, drug quantities, and drug types).
7. Accounting methods (including nomenclature, coding, data processing).
8. Pharmacological aspects (including generic equivalents vs. clinical equivalents).
9. Clinical aspects (including formulatory systems).
10. Legal and fiscal aspects.
11. Impact of proposed methods of purchasing prescription drugs on costs and quality of patient care, on medical profession, on pharmacy profession, on drug industry, on government.

Measles Eradication

Surgeon General William H. Stewart says that measles (Rubella) should be eradicated this year but other cripplers and killers like venereal disease and cancer still baffle researchars.

"This year, 1967, may well go down in history as the year of measles eradication in the United States," Stewart told a House Appropriations Subcommittee, in testimony recently published.

Stewart said the measles vaccine, licensed four years ago, is "bringing the disease to the vanishing point." The Public Health Service researchers now are working with an "experimental vaccine" trying to conquer German measles, he said.

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Malcolm G. MacAulay, M. D.
Don L. Weston, M. D.
J. William Giesen, M. D.

Don Phillips, Administrator
R. Lindsay Shuff, M. H. A.
Asst. Administrator
Social Service:
Harold M. Cook, M.S.W.

AFFILIATED CLINICS

Bluefield Mental Health Center
525 Bland St., Bluefield, W. Va.
David M. Wayne, M. D.

Beckley Mental Health Center
109 E. Main Street, Beckley, W. Va.
W. E. Wilkinson, M. D.

Mental Health Clinic
Professional Building, Wise, Va.
Pierce D. Nelson, M. D.

Obituaries

SELVIA OSCAR FRY, M. D.

Dr. S. Oscar Fry of Charles Town died in Weston on May 23. He would have been 70 on June 1.

A native of Edinburg, Virginia, Doctor Fry was a former practicing surgeon in Charles Town and Martinsburg. He received his pre-medical and medical education at the University of Virginia, the University of Cincinnati and New York University.

For a time, he taught surgery at Columbia University and practiced in New York City.

Doctor Fry was an honorary member of the Eastern Panhandle Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include two sons, Dr. Richard Fry of Gainesville, Florida, and Dr. Louis Fry of Mercus Island, Washington; one sister, Mrs. Bessie P. Cullers of Charles Town; four grandchildren; and two nephews.

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WVU MEDICAL CENTER NEWS—(Cont.)

Reed General Hospital; Jon R. Morgan, Charleston, Mound Park Hospital, St. Petersburg, Florida; Jimmy D. Morrison, Huntington, Cabell-Huntington Hospital; and Anthony J. Oliverio, Fairmont, WVU Hospital.

Louis C. Palmer, Morgantown, Harrisburg Polyclinic Hospital; Nola J. Palomino, Fairmont, Baltimore City Hospital; Gerald A. Ravitz, Verona, New Jersey, WVU Hospital; David A. Santrock, Dunbar, U. S. Naval Hospital, Portsmouth, Virginia; and Linda L. Shaffer, Clarksburg, Mound Park Hospital, St. Petersburg, Florida.

David L. Shifrin, Carnegie, Pennsylvania, St. Francis General Hospital, Pittsburgh; Jeffrey S. Shultz, Shepherdstown, WVU Hospital; Nancy A. Sibert, Follansbee, Harrisburg Polyclinic Hospital; Scott L. Sibert, Brownsville, Pennsylvania, Harrisburg Polyclinic Hospital; and Richard H. Sibley, Nitro, Hennepin County General Hospital, Minneapolis.

Rutherford C. Sims, Raysal, WVU Hospital; Michael L. Steiner, Huntington, Los Angeles County General Hospital; Danna C. Swan, Huntington, University of Kentucky, Lexington; Nancy Selove Wanger, Martinsburg, WVU Hospital; Robert K. Webb, Sistersville, Brooke General Hospital, San Antonio, Texas; and Jeffrey M. Yost, Paden City, Brooke General Hospital, San Antonio.

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County Societies

B-R-T

Dr. Juan Kusior, Director of the Appalachian Mental Health Center in Elkins, was guest speaker at the regular monthly meeting of the Barbour-Randolph-Tucker Tri-County Medical Society which was held in Parsons on May 18.

Doctor Kusior discussed the services of the Center in the community.

A letter from the Taylor County Medical Society requesting that it be taken into the Barbour-Randolph-Tucker Medical Society on approval of the Council was read and approved.

Dr. Richard A. Cuonzo of Parsons was elected to membership in the Society.—A. Kyle Bush, M. D., Secretary.

* * * *

CABELL

The regular monthly meeting of the Cabell County Medical Society was held on May 11 at the Holiday Inn in Huntington, with members of the Cabell County Bar Association as guests.

The speaker was Mr. Harry C. Harshman, Vice President of Marine Midland Corporation of New York and a member of the New York Bar. He presented an interesting talk on "The Outlook for the Economy and the Securities Markets." His outlook on the economy for 1967-68 was optimistic.

Eighty-two members and guests attended the meeting.

A special business meeting of the Cabell County Medical Society was held at Cabell-Huntington Hospital on May 25 with 34 members in attendance.

The Society adopted a resolution calling the business and occupation tax levied on professions recently by the Huntington City Council illegal and unfair. The resolution also called for the Society to assist other professions in combatting the tax in the courts and levied an assessment of not more than $25 per member for this purpose.—Harold N. Kagan, M. D., Secretary.

* * * *

KANAWHA

Dr. Rex B. Conn, Jr., Associate Professor of Pathology at the West Virginia University School of Medicine, was guest speaker at the regular monthly meeting of the Kanawha Medical Society, which was held in Charleston on May 9.

Doctor Conn's topic was "What Is the Future of the Clinical Laboratory?" He said the "clinical laboratory is taking more and more of the patient's dollar" and predicted that in the next few years all clinical laboratories will be licensed and required

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to meet minimum standards.—Don Crislip, Executive Secretary.

* * * *

MERCER

Dr. W. F. Hillier, Jr., of Bluefield was the scientific speaker at the regular monthly meeting of the Mercer County Medical Society, which was held in Bluefield on May 15.

Doctor Hillier gave an interesting talk on "Management of Strokes." He presented several case histories and outlined treatment with vasodilators and anticoagulants. Cerebral angiography also was discussed.

Dr. Frank J. Holroyd of Princeton, Co-chairman of the WESPAC Board of Directors, moved that WESPAC dues be included on the dues statements for next year. The motion was adopted.—John J. Mahood, M. D., Secretary.

* * * *

McDOWELL

The regular monthly meeting of the McDowell County Medical Society was held at Stevens Clinic Hospital in Welch on May 10.

Two physicians and two ministers participated in a medicine and religion program.

Twelve members and 10 guests, including eight ministers, attended the meeting.—J. C. Ray, M. D., Secretary.

MONONGALIA

Dr. Alvin L. Watne, Associate Professor of Surgery at the West Virginia University School of Medicine, presented the scientific program at the regular monthly meeting of the Monongalia County Medical Society, which was held in Morgantown on May 2.

Doctor Watne gave a very informative lecture on "Chemotherapy in Solid Tumors."

The Society approved a motion calling for a Measles Vaccine Day similar to Polio Vaccine Days of the past. Dr. W. Gene Klingberg was appointed Chairman of the program.—Robert Greco, M. D., Secretary.

* * * *

RALEIGH

Dr. Peyton E. Weary of Charlottesville, Virginia, was guest speaker at the regular monthly meeting of the Raleigh County Medical Society which was held at Henry's Patio Room in Beckley in May.

Doctor Weary, Associate Professor of Dermatology at the University of Virginia School of Medicine, gave an interesting talk on the treatment of early skin cancers.

The Society adopted a resolution honoring Dr. Ralph Gwinn Broaddus, who recently completed 50 years of medical practice.

Members decided not to undertake sponsorship of measles vaccine clinics throughout the county but it was suggested that physicians should feel free to donate their time, on an individual basis, to these clinics.—Forest A. Cornwell, M. D., Secretary.

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McDOWELL

The regular monthly meeting of the Woman's Auxiliary to the McDowell County Medical Society was held at the Presbyterian Church in Welch on May 10.

Officers for the coming year were introduced. Mrs. J. H. Murry began the second year of her two-year term as President.

Serving with her as officers are: Mrs. A. A. Carr, President Elect; Mrs. Dante Castrodale, First Vice President; Mrs. J. C. Ray, Second Vice President; Mrs. A. J. Villani, Secretary; and Mrs. John Cook, Treasurer.—Mrs. C. F. McCord, Corresponding Secretary.

* * * *

MERCER

New officers were installed at the May meeting of the Woman's Auxiliary to the Mercer County Medical Society, which was held at the home of Mrs. John J. Mahood, the retiring President.

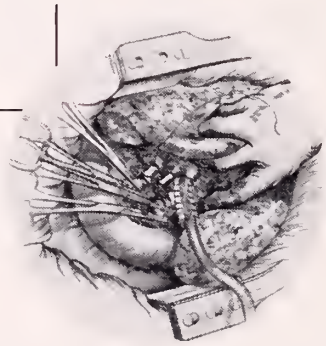
Mrs. John J. Bryan took office as President. Other new officers for the coming year are: Mrs. C. D. Pruett, Vice President; Mrs. Sam Milchin, Recording Secretary; Mrs. R. O. Rogers, Jr., Corresponding Secretary; and Mrs. Frank J. Holroyd, Treasurer.

Mrs. Mahood thanked the group for its splendid cooperation during her term. Assisting her as cohostesses were Mrs. Joe E. McCary and Mrs. Frederic C. Goodall.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

MEDICAL ART



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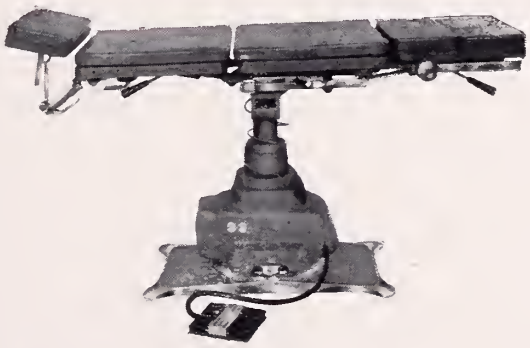

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In view of the nature of this hospital, the services it performs to the citizens of this State, the new programs which are planned to expand our rehabilitation services and the many other advantages attendant to this position, I can recommend it without reservation to the members of the medical profession who may desire to enter the field of medical administration without completely abandoning the practice of their profession.

I would be pleased to discuss in detail the responsibilities of this position with any physician who desires such a conference.

Again, I extend to you my sincere appreciation for your assistance in this matter.

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According to the Medical Board, the selected recordings represent the latest and most authoritative reviews of modern-day diagnosis and treatment, in the actual voices of Amerca's finest teachers and clinicians. This special library of titles represented the best of programs produced in the regular subscription programs of the Audio-Digest Foundation (a nonprofit subsidiary of the California Medical Association) during the past several years.

The Catalog of Classics is available free of charge and may be obtained by writing the Audio-Digest Foundation at 619 S. Westlake Avenue, Los Angeles 90057.

Annual Otolaryngologic Assembly

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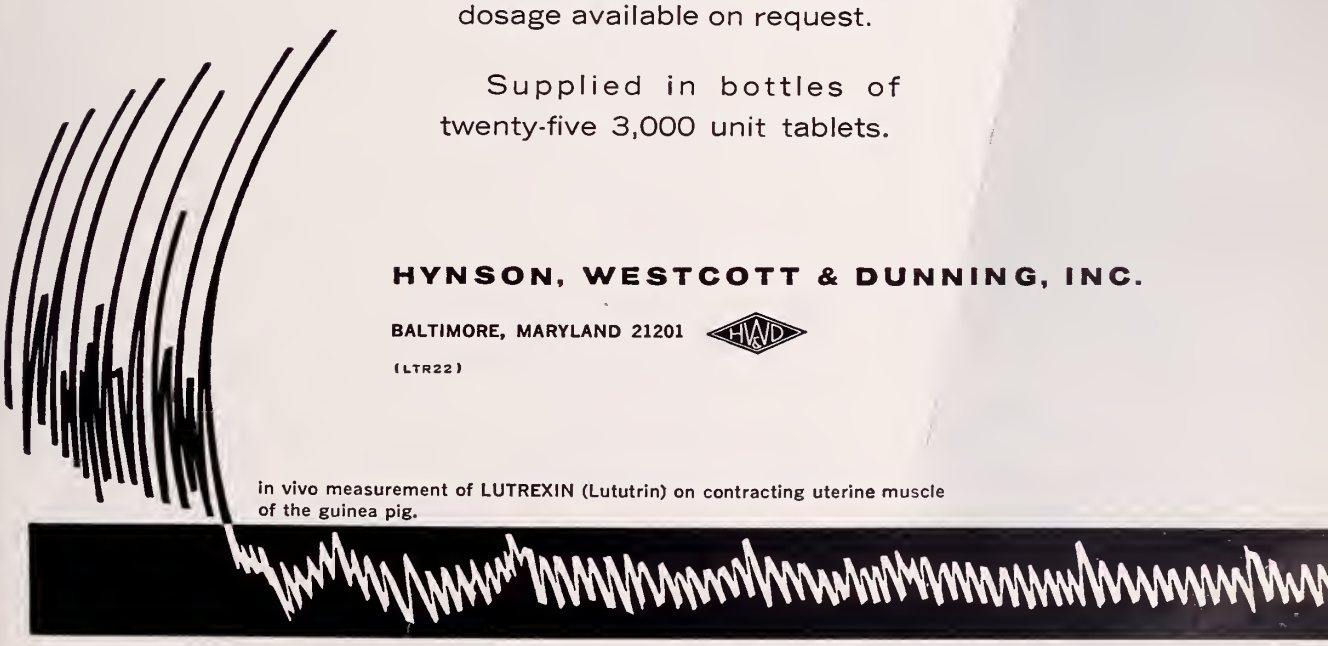

in vivo measurement of LUTREXIN (Lututrin) on contracting uterine muscle of the guinea pig.

AUGUST
1967

Vol. 63 No. 8

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50c per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

Member 1967

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The West Virginia Medical Journal

Vol. 63, No. 8 August, 1967

Management of Diabetes Mellitus*

Theodore G. Duncan, M. D.

Diabetes mellitus, unlike acute illnesses, requires not only initial diagnosis and treatment, but a definite, continuing, educational program for the patient and his relatives. This, in addition to good medical management, will enable the young patient to grow in equal stature with his peers and to achieve an active and fruitful life in his community. The adjustments of diet, insulin or oral anti-diabetic agents are patterned to permit full and varying activity. This may be achieved only when the patient has a working knowledge of the action of insulin and its interrelationship to diet and exercise. The patient must have a basic understanding of diabetes as an aid in preventing complications and in attaining good control of the disorder. It is well for him to realize that there are different degrees of severity of diabetes and that each, influenced by complications, has a bearing on the conduct of treatment and the adjustments necessary from time to time.

The Author

- **Theodore G. Duncan, M. D., Assistant Physician to Pennsylvania Hospital in Philadelphia; and Associate in Medicine, University of Pennsylvania School of Medicine.**

Classification and Diagnosis of the Stages of Diabetes

1. *Prediabetes.*—This stage may not be easily detected by routine laboratory studies as no definite sugar abnormality is apparent. Electronic microscopic studies indicate changes in the arteriolar basement membrane in the kidney and muscle that are characteristic of diabetes. This stage should be suspected in persons with bilateral family history of diabetes and in a "nondiabetic" identical twin of a diabetic. Others suspected are those with unexplained neuropathy, retinopathy or nephropathy, obese persons, and women with an abnormal obstetrical history.

2. *Chemical Diabetes.*—In addition to the changes demonstrated in prediabetes, this next stage has a definite abnormality in carbohydrate metabolism, but only after the stress of a meal or glucose taken as part of the oral glucose tolerance test (OGTT). A fasting blood sugar value or findings in random specimens of urine frequently are normal but do not exclude diabetes. When chemical diabetes is suspected, an oral glucose tolerance test is indicated. Diabetes should be expected in all "close relatives" of a diabetic patient in addition to those mentioned in the discussion of the prediabetic state. Lacking symptoms, in these subjects, the diagnosis is easily missed and the diabetes is allowed to progress unfavorably. Experience has proven that the oral glucose tolerance test is the most practicable test for the detection of diabetes mellitus[1] when the diagnosis is not apparent. But, before this test, in order to obtain full functional capacity of the beta cells, a diet normal in carbohydrate intake (minimum of 150 gm. per day) must be eaten for at least one week.[2] The upper limits of normal blood sugar concentration for an adult up to the age of 50 are: fasting 110; one hour 170; two hours 120; three hours 100 mg./100 ml. (true glucose). If the fasting and three-hour values are elevated or if the two-hour value is greater than 130 mg./100 ml., the test is considered abnormal.[2, 3] Also, diabetes may be considered if three or more of the values are elevated. If there is doubt about the accuracy of the oral glucose tolerance test because of nausea or vomiting during the test caused by the "glucose load," the test may be repeated

*Presented before the 15th Annual Scientific Assembly of the West Virginia Chapter, AAGP, in Huntington, April 28-30. Submitted to the Publication Committee, May 1, 1967.

after the lapse of two or three days or an intravenous glucose tolerance test may be employed as a means of eliminating influences of disturbances in the digestion or the absorption of the glucose.

3. *Clinical Diabetes.*—Polyuria, polydipsia, and polyphagia, the classical symptoms of poorly controlled diabetes, usually develop more gradually in the adult non-ketotic diabetic than in the juvenile ketotic type. Nausea, vomiting and weight loss occur as ketosis progresses. Urinary tract infections, neuropathy, retinopathy, nephropathy, arteriosclerotic heart disease, and peripheral vascular disease are common complications. The fasting or random blood sugar level usually is abnormally higher, thereby eliminating the necessity of a diagnostic glucose tolerance test.

Diabetes: Juvenile and Adult Types

All patients with the primary forms of the disease have either juvenile or adult type of diabetes. The distinction is important as the pancreas in the juvenile type produces no appreciable amount of insulin or none at all; hence, there is the life saving necessity for exogenous insulin in all such cases. Ketosis and coma may develop if treatment with insulin is not adequate or if complications are present. In contrast, the adult non-ketotic type of diabetes produces insulin, usually a greater amount than normal, but it is ineffectively utilized; oral hypoglycemic agents usually are sufficient, especially in overweight patients, to maintain normal blood sugar concentration. The necessity for insulin and not the age at onset determines the type of diabetes, although usually the non-ketotic "adult onset type" occurs after 30 years of age, and the ketotic juvenile type in the younger age groups. The onset of the juvenile type of diabetes may occur, but uncommonly, in older age groups. In the case of the juvenile diabetic patient, after the initial hyperglycemia and complication are treated with insulin, there may develop a period of complete remission which lasts for several months. During this temporary phase, small doses of insulin or an oral hypoglycemic agent are adequate to control the diabetes.

Oral Hypoglycemic Drug Therapy

Selection of Patients.—The oral hypoglycemic agents usually are effective in maintaining glycemic equilibrium in patients with the onset of diabetes beyond the age of 30 years who have been receiving a small amount of insulin. These drugs are not suited for use in the juvenile diabetic nor do they improve the ease of control when used in conjunction with insulin in these cases. Patients with a mild, stable, adult type of diabetes, if receiving less than 20 units of insulin, may have the insulin discontinued when starting an oral hypoglycemic agent. If they are receiving from 20 to 40 units, the insulin should be reduced from 30 to 50 per cent when the oral medication is given, with further daily reduction as response to the oral drug occurs. Patients taking more than 40 units of insulin should have a 20 per cent reduction in insulin when an oral drug is started, with further careful reduction as response is observed. Some obese diabetic patients receiving as much as one hundred units of insulin may be well controlled with an oral agent if there is adequate weight reduction by therapeutic means.

A Method of Differentiating Juvenile Diabetes from Adult Diabetes

The differential diagnosis between the two types of diabetes usually is made without difficulty by observing the ease of control and the age and rapidity of onset of symptoms. Occasionally there is some doubt, especially in the obese adult patient receiving a large dosage of insulin whose onset of diabetes occurred later in life. If such a patient is given a "no-calorie" diet[4] for three or four days without exogenous insulin, and glycosuria and hyperglycemia disappear, the patient requires no insulin and may be successfully treated after the fast with a single or combination of oral hypoglycemic agents (Figure 1). Conversely, if glycosuria appears or persists in conjunction with acetonuria, oral therapy will not control the diabetes and insulin therapy is essential as it is in cases of juvenile diabetes (Figure 2). If insulin therapy and food are not given promptly in such cases, diabetic coma will occur and for this reason the "no-calorie" test must be conducted during hospitalization. Acetonuria develops in two or three days in all persons deprived of all food, and the ketonuria without glycosuria is mild and innocent for it is caused by the starvation and not by the diabetes.

Types of Oral Hypoglycemic Agents

Two types of oral hypoglycemic agents are available for treating the adult stable type of diabetes: the sulfonylurea group and the biguanide phenformin (Table 1). The sulfonylurea drugs are Tolbutamide (ORINASE), Acetohexamide (DYMELOR), Chlorpropamide (DIABINESE), and Tolazamide (TOLINASE). These stimulate and promote the release of insulin by the beta cells of the pancreas. The biguanide (Phenformin - DBI and DBI-TD) is believed to aid the utilization of glucose by increasing the peripheral glucose metabolism (intracellular hydrolysis) by reducing neoglu-

cogenesis and by decreasing the output of glucose from the liver. It does not stimulate the release of insulin by the beta cells. In fact, it decreases the amount of insulin circulating in the blood. The hypoglycemic action, unlike that of the sulfonylurea, is not effective in the nondiabetic patient.

The Sulfonylurea Group.—Presently, four oral sulfonylurea drugs which function in a similar manner are available for the treatment of adult diabetes. They differ mainly in potency and duration of action (See Tables 1 and 2). Tolbutamide, the shortest acting and least potent, usually is given in one or two daily doses, whereas Acetohexamide, Tolazamide and Chlorpropamide usually are given as a single daily dose before breakfast. The ability of a drug to give good glycemic control when given once daily is a distinct advantage, since patients requiring multiple daily doses frequently forget the dose at lunch or supper. Poorer control of the diabetes results. The degree of control may be improved by substituting a longer acting drug for one with a shorter duration of blood sugar lowering effect.[5] The degree of potency per milligram of drug increases progressively from Tolbutamide, Acetohexamide, Tolazamide to Chlorpropamide. The latter two are quite similar. Mild hypoglycemia, when encountered in the stronger medications, is most easily eliminated by decreasing the dosage, but when hypoglycemia is caused by Chlorpropamide, it poses a greater problem because its hypoglycemic effect may persist as long as 60 hours. Satisfactory responses to sulfonylurea drugs may gradually subside. These are then "secondary failures." Secondary failures occur in 10 to 30 per cent and are related to insufficient dosage, poor selection of patients, excessive caloric intake or an intervening complication. The requirement for oral hypoglycemic agents, as with insulin, varies from time to time calling for adjustments in dosage. Failure to maintain excellent control of the diabetes with sulfonylurea drugs invites "secondary failures." If poor control exists when the maximal dosage of Tolbutamide is given, a more potent drug with a longer hypoglycemic effectiveness is indicated. A one to three-week trial of therapy may be necessary before judging a drug's maximal effectiveness. Trial therapy may continue for these periods even though glycemic equilibrium is not achieved, if acetone does not appear in the urine. Acetonuria and glycosuria indicate poor control and usually insulin is indicated at least temporarily. The combination of Phenformin and a sulfonylurea is more effective than either drug separately. The most potent combination of oral

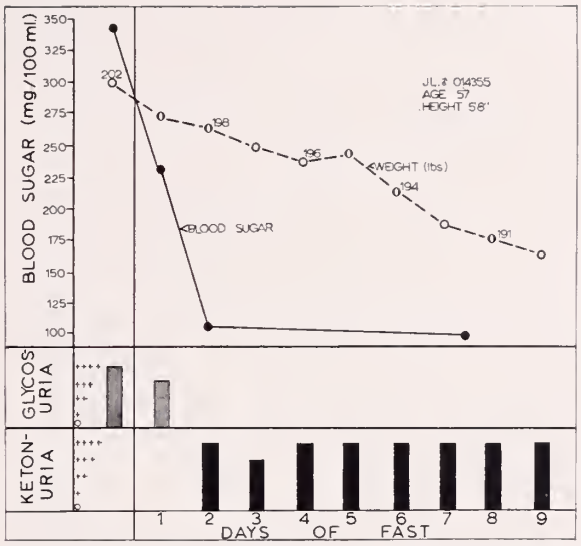

Figure 1

This adult type of diabetic when given a no-calorie diet without hypoglycemic medication had clearing of the glycosuria and a prompt return of the blood sugar to normal. Acetonuria normally occurs.

Complications Of Fasting In The Severe Diabetic

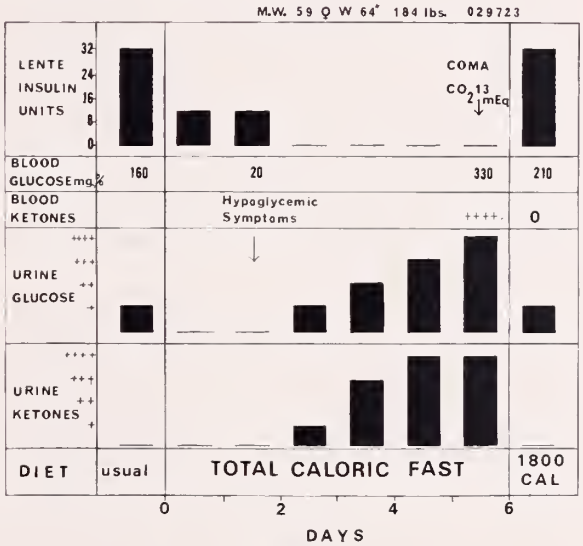

Figure 2

This juvenile-ketotic diabetic when insulin was stopped during a total caloric fast developed marked glycosuria, ketonuria, then coma. The appearance of glycosuria during a total caloric fast shows that juvenile type of diabetes exists and insulin therapy is necessary.

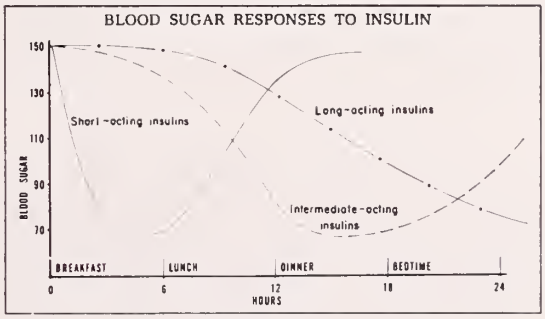

Figure 3

agents is Chlorpropamide, 500 mg. with long acting Phenformin (DBI-TD, 50 mg.) twice daily. If this is ineffective, insulin is indicated.

Complications of sulfonylurea drugs are uncommon, but do include hypoglycemia (most frequent when Chlorpropamide is employed), nausea, vomiting, diarrhea, dermatitis, blood dyscrasias and cholestatic jaundice.

Biguanide Compounds.—Phenformin, usually used in its longer acting form (DBI-TD), is effective in easily controlled adult diabetes. It does not cause hypoglycemia in normal individuals, but it contributes to the risk of provoking hypoglycemia when it supplements insulin therapy. There is increasing evidence of weight reduction when this drug is used[6] in the obese diabetic patient. When DBI is used, it is started in the smallest dosage and gradually increased, if tolerated, to the optimal dose, not to exceed 200 mg. daily. A decrease in appetite, increased sensitivity to alcohol, changes in personality and gastrointestinal symptoms may occur. It is unique in that it may be used as an effective supplement to a sulfonylurea drug. Infrequently, in juvenile diabetes, it is useful in combination with insulin (See section on insulin therapy). There have been reports of lactic acidosis in patients receiving Phenformin, but a direct relation has not been established. The drug should not be used in patients with hepatic or renal insufficiency and should be terminated in patients having anoxia or appreciable degrees (3 - 4) of acetonuria.

The preferred use of oral hypoglycemic agents in chemical or mild clinical diabetes is undisputed if they effectively correct the hyperglycemia "around the clock." There is evidence that Phenformin[7] as well as the sulfonylureas[8] is capable of retarding the progression from prediabetes to the active clinical diabetes. These drugs will not serve as complete substitutes for insulin in juvenile type (labile) diabetes, but Phenformin (DBI-TD) successfully supplements insulin therapy when it replaces a small evening dose of insulin. The sulfonylurea drugs have no place in the treatment of the juvenile type of diabetes. Neither sulfonylureas nor Phenformin should be given during pregnancy, during acute complications nor in patients with renal or hapatic insufficiency.

Insulin Therapy in Diabetes Mellitus

Effective treatment of patients with juvenile diabetes requires periodic evaluation to insure optimal health and activity. No two patients will require identical regimens. Many factors—physical activity, pregnancy, menses, growth, infection—influence the need for insulin and diet.

A specific pattern of treatment, however, becomes evident for each patient and once established only minor changes in the dosage of insulin and diet are needed to maintain optimal glycemic equilibrium. Diabetes is controlled by combinations of insulin therapy, special diet, and physical activity. Only insulin therapy will be discussed in detail.

Insulin Therapy.—In some cases diabetes can be controlled with oral blood sugar lowering agents and a restricted diet, but in others treatment *must* be with insulin, notably: (1) children, (2) malnourished adults with labile diabetes, (3) pregnant women, (4) those with acute complications and (5) adults whose diabetes is not controlled by diet alone or with oral antidiabetic drugs.

A review of the types and actions of insulin in its various forms (Figure 3) provides a foundation upon which to base treatment.

Rapidly acting insulins.—Crystalline (regular) and semilente insulins, when given immediately before breakfast, have a blood sugar lowering effect until noon. Crystalline insulin given subcutaneously has its beginning effect within one hour and a maximal duration of action between two and six hours. Semilente insulin effect is one or two hours slower at onset but has the same duration of action. An excessive dose of either insulin will cause a hypoglycemic reaction during the latter portion of the morning. A nourishment given at mid-morning decreases the likelihood of hypoglycemia. Rapidly acting insulins are used in combination with intermediate and, less frequently, with long acting insulins for maintenance therapy and are rarely the sole means of control unless complications exist.

Intermediate acting insulins—neutral protamine Hagedorn (NPH), lente, and globin—exert a slower blood sugar lowering effect. If given before breakfast, their action usually extends from midafternoon until late evening. An excessive dose may cause an "insulin reaction" before supper or during the evening, but a nourishment taken in midafternoon or late afternoon decreases this likelihood. The intermediate and short acting insulins may be mixed in a syringe and given 30 minutes before breakfast. A small dose of NPH or lente insulin, given at supper or bedtime, will prevent early morning glycosuria in cases of labile or juvenile type diabetes.

Long acting insulins—ultralente and protamine zinc insulin (PZI)—are given before breakfast and cause a blood sugar lowering effect from late evening until breakfast the following day. An excessive amount of these insulins tends to

cause a hypoglycemic reaction between midnight and breakfast time of the following morning. They are used only in conjunction with a short or intermediate acting insulin. Ultralente has largely replaced PZI as small amounts of rapidly acting insulins can be mixed with it without appreciably changing their characteristic blood sugar lowering effects. Long acting insulins are most commonly used to prevent prebreakfast glycosuria if other measures have failed. The effect of a dose of ultralente insulin carries over well into the second 24 hours—an appreciably longer effect than in the case of PZI.

Adjustment of Insulin and Diet According to Degree of Glycosuria.—Table 3 shows eight specific patterns of glycosuric imbalance, and the text following explains the rationale for the recommended dosage adjustments.

1-2. *Late morning glycosuria and insulin reaction before supper.*—The addition of a short acting insulin mixed with NPH given before breakfast will decrease glycosuria. In order to prevent hypoglycemia in the latter portion of the afternoon, a small decrease (2-4 units) of NPH insulin sometimes is necessary. If hypoglycemia does not exist in the latter portion of the day, NPH need not be decreased (Table 3, example 2).

3-4. *Glycosuria during the afternoon or evening.*— The addition of a small amount of NPH insulin given before breakfast will have greater blood sugar lowering effect during the latter portion of the day. But, if no glycosuria is present before lunch, the crystalline insulin also should be decreased by 2 or 4 units to prevent insulin reactions before lunch (Example 4).

5. *Persistent aglycosuria* in juvenile diabetes may indicate impending hypoglycemia. Patients are instructed to reduce the intermediate acting insulin by two units so that a mild degree (trace or 1 plus) of glycosuria occurs once or twice per day.

Blood glucose determinations aid in excluding a high renal threshold for glucose, i.e., absence of glycosuria when the levels of the blood sugar are above the normal renal threshold. In this case, freedom from glycosuria does not indicate impending hypoglycemia and the blood sugar determinations are of special value as guides in controlling the diabetes. Glycosuria in the presence of a high renal threshold is indicative of diabetes markedly out of control.

6. *Glycosuria occurring before breakfast* usually is not eliminated by increasing the morning dose of NPH insulin without causing hypoglycemic reactions before supper. This problem may be prevented by:

(1) replacing NPH insulin with lente insulin because of its longer blood sugar lowering effect; or

(2) a small dose of an intermediate acting insulin after supper may be effective.

(3) if the diabetes is well controlled except for glycosuria before breakfast, 50 mg. of long acting phenformin (DBI-TD) after supper frequently suffices to effectively lower the blood sugar for a 12-hour period. This is an established instance in which a drug orally aids in the control of juvenile diabetes. Also, if good control has been achieved by insulin given before breakfast and a small additional dose (4-6 units) before or after supper, long acting phenformin may be substituted for the evening insulin. This regimen may be continued as long as there is no early morning glycosuria; should this occur, the phenformin is replaced by an intermediate acting insulin given after supper.

(4) exchange an equal dose of long acting insulin such as ultralente for the NPH insulin, and increase the crystalline insulin. Patients receiving long acting insulin alone are likely to have hypoglycemia between midnight and breakfast time and hyperglycemia during the forenoon and early afternoon.

7. *Persistent severe (4+) glycosuria requires prompt action.*—Hospitalization is recommended if good control is not achieved quickly and if an associated complication, e.g., infection or acidosis, is evident.

Persistent four-plus glycosuria not associated with a complication most frequently results from insufficient insulin. It is corrected by increasing the dose of the intermediate and short acting insulin given before breakfast, each four units, and by adding an intermediate acting insulin (4-6 units) before supper. A further increase in all the insulin doses and the addition of a short acting insulin before supper may be required the next day. Larger doses of insulin will be required if hyperketonemia is detectable. With control of the diabetes established, the total requirement for insulin decreases; hence, the dosage is reduced to avoid hypoglycemic reactions.

Crystalline insulin given four times daily (7 A.M. - 1 P.M. - 7 P.M. - 1 A.M.) is the best method of controlling severe glycosuria associated with complications. During this regimen, the longer acting insulins are discontinued and four equal caloric feedings are given at six-hour intervals after each injection of insulin.

Table 1

ORAL HYPOGLYCEMIC COMPOUNDS

Trade Name	*Generic Name*	*Average Daily Dose*		*Maximal Daily Dose*	*Duration of Action*
ORINASE	Tolbutamide	0.5 to 3 gm.	D.D.	3 gm.	6 - 12 Hrs.
DYMELOR	Acetohexamide	0.25 to 1.5 gm.	S.D.	1.5 gm.	12 - 24 Hrs.
TOLINASE	Tolazamide	100 mg. to 1 gm.	S.D.	1 gm.	6 - 16 Hrs.
DIABINESE	Chlorpropamide	100 to 500 mg.	S.D.	0.5 gm.	Up to 60 Hrs.
DBI	Phenformin	50 to 200 mg.	D.D.	0.2 gm.	4 - 6 Hrs.
DBI-TD	Phenformin	50 to 200 mg.	D.D.	0.2 gm.	8 - 12 Hrs.

D.D. = divided daily doses S.D. = Usually single daily doses

Table 2

RELATIVE POTENCY OF SULFONYLUREA COMPOUNDS

Tolbutamide	1000 mg.
Acetohexamide	500 mg.
Tolazamide	250 mg.
Chlorpropamide	250 mg.

Table 3

PLANS FOR ADJUSTING INSULIN ACCORDING TO DEGREE OF GLYCOSURIA: EIGHT ILLUSTRATIVE EXAMPLES

Examples	*Degree of Glycosuria* 7 a.m.	11 a.m.	4 p.m.	9 p.m.	*Current Insulin Dosage (Units)*	*Recommended Adjustments*
1	tr†	4+	0*	0	20 NPH	Decrease NPH** to 16 units; mix with 4 units of crystalline insulin—give 30 minutes before breakfast.
2	tr	4+	1+	tr	16 NPH 4 crystalline (mixed)	Add 2 or 4 units of crystalline insulin to NPH and give one hour before breakfast.
3	1+	tr	3+	4+	16 NPH 8 crystalline (mixed)	Small additional (4-6 units) to NPH given before breakfast.
4	0	0	tr	4+	16 NPH 8 crystalline (mixed)	Small additional (4-6 units) to NPH given before breakfast and decrease crystalline insulin 2-4 units.
5	0	0	0	0	16 NPH 4 crystalline (mixed)	Decrease NPH dosage to 14 units and retain crystalline insulin.
6	4+	3+	1+	1+	18 NPH 4 crystalline (mixed) Give before breakfast	(1) Substitute lente insulin for NPH or, (2) Retain present A.M. dose and give (4-6 units) NPH insulin after supper or, (3) Add a long acting phenformin (50 mg.) at supper time or (4) Substitute an equal amount of long acting insulin for NPH and increase crystalline 4 units.
7	4+	4+	4+	4+	20 NPH 4 crystalline (mixed)	(1) In absence of acute complications, increase NPH and regular insulin by 4 units and add NPH 4-6 units after supper. (2) In presence of acute complications, stop NPH and give sufficient crystalline insulin four times daily (7 a.m. — 1 p.m. — 7 p.m. — 1 a.m.), initial dose 12 units.
8	0	tr	0	0	7 a.m. 1 p.m. 7 p.m. 1 a.m. 15 20 10 15 units of regular insulin	Transition from regular insulin to maintenance therapy — ¾ of total daily requirement of regular insulin (60) = 45 units. Give 40 NPH and 5 regular insulin mixed 30 minutes before breakfast; adjust dosage upward as indicated by degree of glycosuria.

*Insulin reaction.

**Mixture of NPH and crystalline insulin gives best results though in many cases lente and semilente mixtures are equally good. *Note*: Dangers of hypoglycemic reactions will be reduced if a snack (a bread and milk exchange) is given in midforenoon, late afternoon (two hours before dinner) and at bedtime.

†Trace.

8. *Transition from regular insulin therapy to maintenance therapy.*—After crystalline insulin has been given four times daily to control diabetes and the acute complication has been corrected, the precomplication insulin regimen is resumed. In the event that the diabetes is newly discovered during the acute episode, transition to the maintenance plan of insulin therapy is accomplished by giving 75 per cent of the total insulin needed on the 6 hour regimen as 1/5 regular and 4/5 NPH or lente insulin. Subsequent adjusting of the dosage is then determined according to the patient's current needs.

Important Principles of Management.—1. The major causes of insulin reactions are delaying meals, missing snacks, extra physical exercise, correction of acute complications and failure to anticipate the decreasing need for insulin which follows correction of acute complications.

2. Glycosuria may be detected immediately before or during an insulin reaction from urine that was excreted into the bladder during a preceding period of hyperglycemia. In these circumstances, if the bladder is emptied and a second specimen obtained a few minutes later, no glycosuria will be found.

3. Properly trained patients will know what period of the 24 hours each insulin is effective and they are advised to adjust the insulin in small amounts—2 to 4 units—increase in cases of excessive glycosuria and decrease in cases of hypoglycemic reactions.

4. Insulin therapy and dietary regimen can be temporarily altered to permit increased physical activity. A student participating in a racing event or a man playing golf may require a reduction of 4 to 8 units in the morning dose of insulin to prevent insulin reactions.

5. A patient who possesses an understanding of diabetes and its treatment will invariably demonstrate fewer emotional difficulties.

Requests for reprints should be addressed to the author, 330 S. 9th Street, Philadelphia, Pennsylvania 19107.

References

1. O'Sullivan, J. B. & Mahan, C.: Blood Sugar Levels, Glycosuria and Body Weight Related to Development of Diabetes Mellitus, JAMA 144:587-592 (Nov. 8) 1965.
2. Beaser, S. B.: Diagnosis of Early Diabetes Mellitus, JAMA 199:835-836 (Mar. 13) 1967.
3. Duncan, G. G.: Diseases of Metabolism, Philadelphia, W. B. Saunders Company, Chapter 14, p. 961, 1964.
4. Duncan, G. G., Duncan, T. G., Hunscher, M. A., Schless, G. L. & Cristofori, F. C.: Intermittent Total Fasts and Obesity, Postgrad. M. 38:523-535.
5. Duncan, T. G., Smith, J. B. & Duncan, G. G.: Comparative Clinical Effectiveness of Tolbutamide and Acetohexamide, (Submitted for Publication).
6. Weller, D. & Lindar, M.: The Fat, Middleaged Diabetic, AMA Scientific Exhibit, New York, 1965.
7. Wilansky, D. L., Hahn, I. & Schucher, R.: Effect of Phenformin on "Prediabetes," Metabolism 14:793-799 (July) 1965.
8. Fajans, S. S. & Conn, J. W.: Tolbutamide—Induced Improvement in Carbohydrate Tolerance of Young People With Mild Diabetes, Diabetes 9:83-88 (Mar.-April) 1960.

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THERE is no simple answer to the question "How Safe are Drugs?" The effective drugs available today have varying degrees of potentiality for producing harmful effects. Can drugs be developed with such specificity of action that all effects but the one desired would be eliminated? This is something to hope for but the reactive mechanisms of the body may also have limits of specificity. If we have to live with new drugs which occasionally produce adverse effects, less trouble will occur if the physician uses them wisely. He can do this only by learning as much as possible about them before he prescribes them and then passing along any additional information gained from his own experience.—Ralph G. Smith, M. D., in *Journal of New Drugs.*

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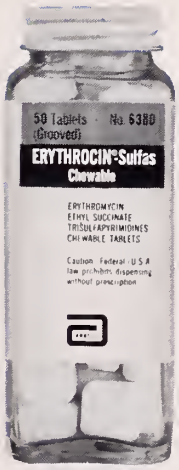

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1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

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Brief Summary on next page

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Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

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Special Article

The Role of West Virginia University in the Graduate And Postgraduate Education of Physicians*

David Z. Morgan, M. D.

We meet today with the opportunity, unique in recent months and years to control our own destiny. For many months, the Committee on Medical Education and Hospitals of The West Virginia State Medical Association under the direction of Dr. Pat A. Tuckwiller, has been evolving a workable plan to improve graduate and postgraduate medical education in our state.

We physicians recently have expended much of our energy on the practical realization of the Medicare law which, although complex in scope, basically is a mechanical prepayment plan for the elderly. More thought, time and energy will be required to implement Title XIX.

I mention these items only to point out that the future stakes of our deliberations today not only are entirely different but infinitely greater. The goal, simply stated, is augmentation of the quantity and quality of medical care to the citizens of West Virginia. If this is a worthy goal, capable of achievement, it deserves our best efforts. Hopefully, no one will be able to look back a few years from now and say "too little, too late." We should be aware of the fact that ill-defined plans calling for periodic evidence of postgraduate medical attainment already are being openly discussed at the national level. The report of the Citizen's Commission on Graduate Medical Education, commissioned by the American Medical Association, undoubtedly will result in significant changes in intern and resident training programs.

As we proceed with the planning, we must avoid the problems that the blind men had in describing an elephant. Each of us must divert our own interests, selfish and unselfish, into the common pathway.

Before considering what the specific role of the University Medical Center might be, it might be useful to review objectives and basic principles of continuing medical education programs as set forth by the Council on Medical Education of the American Medical Association:

(1) There should be *Administration* of the continuing education program by responsible persons having the respect and support of the professional staff of the organization or institution, an administration having as its goal an educational program in the highest interest of the medical profession. There should be continuity of administration, evidence of careful advance planning of the program, and a suitable voice by the teaching staff in the continuing education program.

(2) The *Budget* should be adequate to the educational program undertaken and to its continuing improvement.

(3) The *Teaching staff* should consist of physicians and their associates of proven ability, training, and experience, with an interest in and dedication to the development of carefully planned educational programs in the best current intellectual and professional interest of the participating physicians.

(4) The *Curriculum* of any continuing medical education course should be designed to explore with considerable depth one subject or a closely related group of subjects. The educational merit of devoting sufficient consecutive sessions to explore more than superficially the background and advances in one subject is emphasized. The entire course or significant segments of it should be devoted to integrally related subjects rather than having the various hours concerned with unrelated material. The

The Author

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*Presented before a Medical Education Planning Conference, sponsored by the Committee on Medical Education and Hospitals of the West Virginia State Medical Association, at the Daniel Boone Hotel in Charleston on November 13, 1966.

Submitted to the Publication Committee, December 14, 1966.

curriculum of any continuing medical education program should be the result of thoughtful planning well in advance of the date scheduled for the beginning of the program.

(5) There should be available *Facilities* that encourage participative methods of education. Though lectures by professionally well qualified speakers are a means whereby physicians obtain information, it is felt that such a method of education cannot alone provide an adequate continuing education program in the context of modern education. The facilities mentioned above should include the availability, when appropriate to the content of the program, of patients and their case records and other necessary records such as roentgenograms, electrocardiograms, surgical pathology tissues or reports, or both; laboratories; library; conference rooms; classrooms; and audiovisual aids; all adequate for and suitable to the specific program.

(6) The *Educational Methods* should include more than a series of lectures or panel discussions in which the physicians are primarily passive recipients. Methods requiring active participation include live clinics and bedside rounds, seminars, open question periods, laboratory work, and study of patients under supervision.

(7) *Methods of Evaluating* the effectiveness of continuing education programs should be developed.

(8) Each *Physician's Reward* for participation in continuing medical education always should be his improved ability to care for his patients and the stimulation of his own spirit of intellectual adventure.

I would add to this list only the need for personal or group *responsibility* toward a continuing medical education program. This responsibility was discussed by Sir William Osler, in 1905, in a farewell address to Canadian and American medical students.

Brain-Dusting Hardest Task

"The third essential for the practitioner as a student is the quinquennial brain-dusting which oftentimes will seem to him the hardest task of all. Every fifth year, back to the hospital, back to the laboratory, for renovation, rehabilitation, rejuvenation, reintegration, resuscitation and the like. Do not forget to take the notebooks with you, or the sheets, in three separate bundles, to work over. From the very start begin to save for the trip. Deny yourself all luxuries for it; shut up the room you meant for the nursery—have the definite determination to get your education thoroughly and well started; if you are successful you may have, perhaps, enough saved at the end of three years to spend six weeks in special study or, in five years, you may be able to spend six months. Hearken not to the voice of old "Doctor Hayseed," who tells you it will ruin your prospects, who says he "never heard of such a thing" as a young man not yet five years in practice taking three months' holiday. To him it seems preposterous. Watch him wince when you say it is speculation in the only gold mine in which the physician should invest—"Grey Cortex!"

The medical center of today is faced with major problems. Some of these will have gradual solution such as reorientation toward the sociological, biomedical and psychological sciences, required if medicine is to maintain its leadership in health concepts. Other problems are intermediate in their urgency, such as the need to innovate methods of ambulatory care within and without the walls of the center.

We're Responsible Now

The subject of today's discussion—effective cooperation for dissemination and use of medical knowledge—is a responsibility which we must accept now.

How can the Medical Center accomplish these tasks and maintain research programs, teach medical students and house officers and render service to an increasing number of referred patients?

How can a large center which is straining at a budget and overextending its staff in intramural activities suddenly become a "Medical Center Without Walls" without defeating its primary objectives?

The Heart Disease, Cancer, and Stroke Programs obviously will have an impact on the planning and delivery of service and graduate and postgraduate instruction through a regional network of hospitals and supplemental facilities. This as a source of planning and operational funds will give "The Region" new flexibility in this direction, but the transfusion of money and personnel can help most if the cooperative plan and spirit already exist. Whatever the motivation, community hospitals often have sought this relationship more avidly than most medical centers. It is the responsibility of the Medical Center to see that this courtship becomes an engagement.

A smoothly operating program which will encourage the intellectual and physical involvement of the graduate physician and the development of his skill can do much to alleviate

physician shortages provided, of course, that communities continue to move forward in other areas of self-appraisal. I think that all of us are aware of the fact that doubling or tripling the output of physicians does not necessarily insure increased intake for the state.

In this regard, it is my feeling that the Medical Center could do much in a cooperative effort with the West Virginia State Medical Association to make graduates aware of practice opportunities within the state.

It is not possible to speak of a program involving the resident and intern or the practicing physician without considering the role of the student. The inquisitive, eager student can supply the spark and at the same time a sense of satisfaction and achievement to the educator. A selected student can gain much from a well-supervised extramural experience, and the Medical Center can and will support the development of such programs. It would not be realistic, however, to devise a "lock-step" extramural experience for all students, as this does not take into account the individual student's deficiencies, capabilities or future interests.

We can talk generally and glibly about graduate and postgraduate education as though we were certain of the precise methods to use and how to evaluate their success or failure in terms of patient care. Unfortunately, we are not certain in either instance at present. It may be the role of the University to create and test the modes of education and evaluation. This logically would be done in cooperation with engineers, educators, communicators, librarians, and other campus divisions. It would not be advisable to adopt expensive communication techniques without rationale, nor would it be sensible to ignore any method which holds promise. The gimmick, however, must not become an end in itself. Effective learning requires *involvement.*

A Worthy Goal

The cooperative out-reach programs will have as one of their important goals the strengthening of the intern and residency training programs of the community hospital. They will also serve the practitioner well if he exercises his responsibility, because they will involve a minimum of time lost from a busy practice. Physician shortages and simple economics have made obsolete the six-week or three-month "quinquennial period of brain-dusting" that Osler spoke of. I have talked with many physicians who long to do just this, but never do. They sense what Osler knew—the rejuvenating power of an intensive period of study and review away from practice. Only if we can effect adequate patient coverage and soften the economic blow will this be feasible, but it should be seriously considered.

We really cannot foresee all of the changes that we may be required to adapt to over the next months, but we must be prepared as reasonable men to debate any differences and to move forward.

Winston Churchill, in 1940, in a speech to The House of Commons said, "If we open a quarrel between the past and the present, we shall find that we have lost the future."

Ban on Brands—A Body Blow

There is certainly room for generic drugs. But the effort to curb the branding of all drugs would be a disastrous body blow to the public. Countless research efforts, conducted at heavy expense both in money and manpower, come to nothing. Others produce valuable but specialized drugs, needed and used by but a few people who would die without them. The successful drugs in wide use must carry the costs. There is no other way. A trade name is the producer's guarantee of quality. And it rewards research and development which mean help to sufferers from the endless ailments which plague mankind. Why put a brake on medical progress—the road to ever better health.—Editorial in *St. Louis County Medical Society Bulletin.*

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Special Article

The Role of the Community Hospital in Graduate And Postgraduate Medical Education*

Daniel Hamaty, M. D.

THE ultimate mission of all medical education is to deliver effective health care to the public. Unfortunately, organized medicine—particularly the American Medical Association and its Council on Medical Education and Hospitals and the Association of American Medical Colleges with its medical schools—has drawn rigid lines of authority and communication resulting in splintering medical education into premedical courses, admission committees, preclinical medical school years, the clinical years, the graduate internship years and the graduate residencies, the fellowships and, finally, postgraduate or continuing education.

As if these clearly demarcated but paradoxically poorly defined courses were not enough, everybody has declared open season on those courses following the conferring of the medical degree. The internships and residencies arose from the nonuniversity or community to meet the needs both of the teachers (the practicing physicians) and the students (the young M. D.'s with no skill or experience). The medical schools' hospital staffs, being made of essentially the same stuff as their nonuniversity colleagues, soon established their own internships and residencies, and another separation occurred: the university versus the nonuniversity graduate training programs.

Similarly, postgraduate education was borne away from the university within the structure of professional societies, i.e., the American Board of Ophthalmology, in 1915, and soon spread to the present 40 specialties, each with its examination, certification and companion colleges or associations, plus para-groups and subgroups with state, regional and county components, most of these in turn duplicated by the specialty sections of the American Medical Association and reduplicated by such regional associations as the Southern Medical Association and the New England Medical Society. Concurrently was born the Joint Commission on Accreditation, with its required medical staff functions for meetings, committees and conferences (audit, death, departmental, clinicopathological conferences, et cetera) that also are duplicated by the requirements of the AMA's Essentials of the Internships and Residencies.

The Author

- **Daniel Hamaty, M. D., Director of Medical Education, Memorial Hospital, Charleston, West Virginia.**

In recent years, university and nonuniversity teaching hospitals have presented traditional and imaginative educational programs live and canned, one-way and two-way, television, telephone, and radio.

Voluntary and public health agencies through the above and separately, also engage in disease-oriented professional and quasiprofessional programs.

Lastly, let us not forget the pharmaceutical houses as well as the journals, both the throw-away and the non-throw-away type.

The trouble is that it isn't working. There still is a 50 per cent failure rate in many specialty boards. There is a serious trend away from general practice. There is an alarming number of solo physicians with no hospital or other professional contact. Attendance figures at most meetings amount to 30 per cent plus or minus 10 per cent of all the constituents. All of these organizations have no means to determine if their educational ventures do, in fact, make their impact felt in the participants' day-to-day practice of medicine. It is hoped that a meeting of this type (the first West Virginia State Medical Education Planning Conference), impossible at national or other geographical levels, will bring

*Presented before a Medical Education Planning Conference, sponsored by the Committee on Medical Education and Hospitals of the West Virginia State Medical Association, at the Daniel Boone Hotel in Charleston on November 13, 1966.

Submitted to the Publication Committee, December 14, 1966.

some order and ideas to these noble yet inefficient and often ineffective efforts.

Graduate Education in the Community Hospital

The present role of graduate education in the community hospital is best expressed in the products of that role.

Service to the patient is a tangible product measured in terms of personal attention, a sometimes painless I. V., hopefully second physical examination and an available hand when the patient's heart stops or he goes into shock, develops respiratory obstruction or needs a laxative.

Service to the attending staff is also easily measured in numbers of histories and physicals, operating room assists and laughs at the attending's jokes. A service the house staff provides the attendings, not measureable but very evident, is a thing called an atmosphere of inquiry and other results of the clash with youth, so necessary for the survival of our profession. Called a two-way street, actual interchange of factual information and transfer of skill to and from the house staff is distinctly present in any good program.

Indicators of Benefit

The ultimate board certification of the residents and the Part III of the National Boards are fairly good indicators of benefit to the intern and resident. Presence of the foreign medical graduates in the program lessens the frequency of the use of these indicators. Subsequent professional activities and competence would be better indicators of the success of the program and this, I submit, is something the hospitals need to do to be certain of an effective program.

If one defines the community as that region around the hospital, encompassing the commercial, mercantile and cultural activities of the area, the most direct benefit of the graduate education is the supplying of physicians in such number, variety and ages that continuing quality and quantity of professional services are insured. To formulate this further, it is necessary to clarify this problem of attracting physicians to an area. You can readily see that the internships and residencies get them there; but to keep them requires not only a good professional, but also social atmosphere that leads to the personal decision as to whether or not to settle in the region. A close-to-home example of this community service is the relative number of alumni at a local hospital that are practicing in the environs. This hospital has supplied 25 per cent of those licensed to practice in the past six years compared with no more than two per cent of any other hospital in or out of the state.

Considering the few studies directed to the subject, there is nothing to support the contention that having an internship and residency program results in better patient care or better doctors. One cannot assign this benefit to graduate education at the community hospital. One can see examples of medical communities without interns or residents with excellent quality of care and a high spirit of inquiry as a result of a continuous injection of young, qualified physicians.

I am forced to rather candidly address the problem of foreign medical graduates in light of the above benefits, particularly considering that in recent years, the foreign medical graduate has accounted for 40 to 50 per cent of the filled house staff positions in West Virginia. The foreign medical graduate comes from a school often of radically different curriculum, a cultural class that is a natural barrier to communication and will return to a foreign community having different medical needs. Few ever plan to take specialty boards and, naturally, are not physicians supplying the community. It also is easy to see how the benefits of the doctors and the patients will be less effective because of the cultural and language barriers.

I do not mean to imply that I am against the foreign medical graduate—just within the stated role of the community hospital, he is less likely to contribute to the elements of that role than the American graduate unless he is a permanent visa immigrant.

I would take this advantage to review a few more indicators of undergraduate and graduate medical education in West Virginia. Compared with other states, West Virginia is thinly populated but in terms of relative population has a reasonable number of internship and residency programs, has almost enough medical students but not enough doctors. (We are much better off than Kentucky which has two medical schools).

The future role of the teaching or community hospital as proposed by the Millis Report is predicated on certain evident trends in medical education and medical practice, mainly that medical knowledge is ever expanding at a pace that requires lifelong learning by the physician, and there is an increasing institutionalization of the medical practice.

The medical schools have long accepted the reality that all they can teach are the basic sciences and conceptual application of them, realizing that within 10 years many of the facts accompanying those concepts or the concept

itself may be wrong. Further, that there is just too little time to get across enough material to the point of a functioning scientific physician and much is left to the graduate (internship and residency) years.

This responsibility of essentially curricular content already has brought about a change in internships and residencies from a purely service and experience goal to one of experience, service and further learning process of facts and skill. Consequently, the Commission, in this report, presents essentially a policy of conferring academic accreditation on the teaching hospital as an institution rather than for separate programs. Concurrently, those hospitals with internship only, and the partial-training residencies, are considered inadequate for such accreditation. Also, to meet this goal of further academic development requires the community hospital to have at least some resources of personnel and material to be certain that the subjects are backed up by authoritative teachers, texts, and other desirable features.

Experiment, Then Apply

The Commission also charges the university medical center and the teaching community hospitals to develop systems of training that will prepare its resident physicians for comprehensive medical practice in the community. It suggests that the schools and their hospitals come up with ideas, experimenting in the center—and eventually applying in a network system of affiliated hospitals. Preparing the intern and resident for practice in the community as it will be five, ten and fifteen years hence is no new goal for the community hospital. A national policy to do this in partnership with the university medical centers *is* new and, I think, a welcome one. The local hospital, be it regional or community, is the obvious place to collect data and, in turn, provide the experience for future community practice, whether it be as a general practitioner (as the Commission states, a "primary physician") or a private practitioner specialist.

Postgraduate (Continuing) Education

If one considers that the internship and residency have been around for about 40 years and were in such a state as to require a citizens commission to make an exhaustive study and report, it becomes a trepid task to consider postgraduate or continuing education that has come of its own in recent years.

As I submitted previously, everybody is in the act. There is no system of accreditation of these programs; but because of the high level of spontaneous quality in our profession, most programs have excellent content and faculty. The problem lies not with the programming but with the overwhelming task of identifying educational needs and motivations, overcoming the heterogeneity of the students and evaluating lasting effectiveness.

New Problem

In continuing education, we are faced with the new problem of the part-time student and fulltime physician instead of the fulltime student in medical school or the part-time physician of the house staff. Our student is now a cog in the community. He is very busy, prosperous, independent and not aspiring to any more certificates to hang on the wall. He is a real person, with a family that he neglects and feels guilty about, tries to meet his diversionary needs with a little golf and tries to look out for the best interest of his community by getting involved with service clubs. In this setting, approximately 14 different organizations (counting pharmaceutical houses and other categories as one) bid for his educational interest. The local hospital is one of the 14. Its activities range from one CPC and staff meeting a month to similar presentations every day, to elaborate television presentations, live and taped, to programmed courses. It is evident that its proximity and daily communication with the practicing physicians make these community hospitals the obvious focal point in the delivery of day-to-day postgraduate education.

The Medical Library

Another hospital education need, albeit in the background, is the medical library. I am afraid that we often forget that the library represents an educational service that allows the practicing physician to seek out at his convenience, learn at his own rate and relearn when he forgets it.

Future Hospital Role

I mention the library last in discussing the current role of postgraduate education to bring it up again in the future role. Every future community hospital will have a definite role in continuing education, regardless of the presence or absence of other medical education activities. I would hope that a library will be the nerve center of these activities, including elaborate, rapid and functional recall systems, including bibliographies, key abstracts, reproduction of articles and monographs, the entire scope of the television system and programmed tests. To provide this will require organization and resources.

Beyond these systems of recall on the demand of the practicing physician of information cogent to a problem at hand will be the usual confer-

ences and seminars and visiting firemen to present isolated subject material. I think these have been exhausted insofar as effectiveness is concerned and there should be little change in their future role in the community hospital.

Returning to the student, we need to address the real problem. It only requires money and a few hired hands to set up the community hospital postgraduate program. The public and private health agencies, the medical schools, the pharmaceutical houses, our professional societies, all stand ready to provide the resources. But can we or will we afford ourselves of these learning services?

There is a school of philosophy in medical education that says there is no such thing as teachers and teaching; rather, there are just students and learning; that is to say, the most important effort is that which the student applies to essentially self-learning. This must certainly apply to the fulltime physician who is a part-time student.

We need to examine the ecology of the postgraduate student: his life, his motivations, his needs. If there is no room for postgraduate education as there may be, then perhaps we have to make some adjustment in his pattern of medical practice to allow for it. We need to consider such problems as income differentials, family responsibility, unnecessary hospital and office administrative burdens, his personal physical and mental health and his virtual isolation to sick people and boring colleagues.

It falls to the family environment of the community hospital staff as they operate their systems of self-discipline to consider these motivational factors openly and sincerely. Only then can they afford themselves of the more elaborate educational devices and more productive educational programs which ultimately will insure their longer professional life as a modern, up-to-date physician—to the point at which the word retirement might mean just a slowing down, never quitting.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

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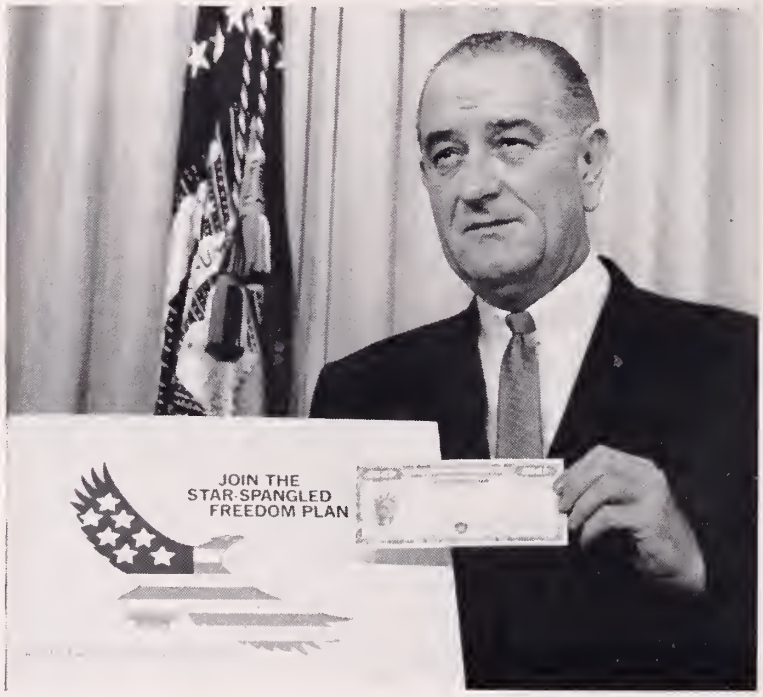

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Centennial Banquet and Ball

Plan to attend a triple feature evening of entertainment commemorating the 100th Anniversary of the West Virginia State Medical Association

- ✶ 6:30 P. M.–Cocktails
- ✶ 7:30 P. M.–Banquet
- ✶ 9:00 P. M.–Centennial Ball

Banquet Speaker: Dr. Perry E. Gresham
President, Bethany College

Chesapeake Hall • The Greenbrier • August 25, 1967

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A message from . . .

The President

FARE THEE WELL

THE end had to come but unlike the beginning it is coming in a relatively short time. It is hard to adequately find the proper words to convey my humble feeling to have been *the* President of the West Virginia State Medical Association. God knows how I've cherished these days and I'm indeed grateful to all of you for permitting me to serve as President.

My thanks to all committees, to all societies who invited me to speak, to the state office and everyone who made my Centennial reign an extremely happy one.

I'm sorry I didn't get to the Medical School and to Monongalia County—snow kept me out.

Personalities should not intervene with county invitations; the Office of the President commands respect and that should be the governing factor; I'm happy to have accepted all invitations—the short speeches in my life are musts.

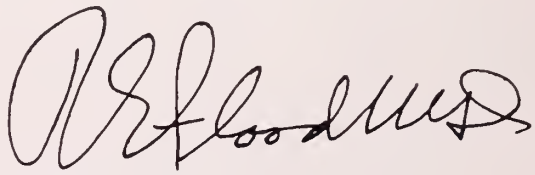
The Pharmaceutical Association honored the West Virginia State Medical Association on its Centennial Anniversary and saw fit to invite the Centennial President to speak at its annual meeting. I assured those assembled how very much our officers and members appreciated this fine gesture. It was a pleasure to be associated with this fine organization—thank you Bill Phillips, et al.

There are many more thank-yous that I should make—I'm grateful for this honor of being President; and, many thanks to Bill, Ed, Mary and Judy of the State Office; Cope, Carole, Dorothy, Mildred and Estelle for carrying on and for working such late hours when I was in my offices; to George Naymick, Ray Greco, Emil Capito and Earl Rosenblum for their excellent care of my patients during my absences; and, to Robert Byrd for his kindnesses in driving me here and there, and to his wife, Shirley, and little Leslie for not minding his absences from home; and, of course, to my family for excusing all my galavanting; for the "abuse" they took from a few people who thought I was always "on vacation;" and, for all their help.

And to all you others I say thank you too. To the Auxiliary for grabbing off the state honors and to my own Hancock County Unit for winning the award and citation from the AMA-ERF. Thank you for a job well done and may the charms, tie bars and cuff links profit start you off to another banner year—a repeat for the year 101!!!

See you at The Greenbrier—and, thanks for coming.

Fare thee well!



RICHARD E. FLOOD, M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

THE 100th

The year 1967 will be remembered as the most eventful and rewarding in the 100-year history of the West Virginia State Medical Association. Official observances have been held throughout the State to commemorate the 100th Anniversary of the founding of the organization, and we pay particular tribute to the Ohio and Marion county medical societies for sponsoring dinner meetings in Wheeling and Fairmont earlier in the year.

The climax will take place during the Centennial Meeting at The Greenbrier later this month. The setting and program will be in marked contrast to the first meeting which was held by the founders in Wheeling 100 years ago. Rather than a handful of interested physicians who answered the call for the first meeting, there should be about 500 physicians in attendance at The Greenbrier, and the total attendance should exceed 800.

The Program Committee and the officers of the Association have spent long hours arranging a program which will be remembered for years to come. Also, the Auxiliary is to be commended for its expertise in handling arrangements for the entertainment features in connection with the Convention. Indeed, the entire program has been planned in such a manner

Richard E. Flood, M. D.
President

that there will be something of interest to one and all.

Physicians, their wives and guests should be particularly interested in attending several of the special sessions. The speaker at the first session of the House of Delegates on Wednesday afternoon, August 23, will be Dr. Milford O. Rouse of Dallas, Texas, President of the American Medical Association. Doctor Rouse served for several years as Speaker of the AMA House of Delegates and during that time succeeded in streamlining the work of the House so that the business agenda today is a joy to behold compared to several years ago. He has many friends in West Virginia and we are delighted he will pay his official visit to West Virginia at the time of our Centennial meeting.

The first speaker at the opening scientific session on Thursday morning will be Dr. William B. Walsh, the Founder, President and Medical Director of Project HOPE. This dedicated physician has traveled throughout the world on the hospital ship S. S. HOPE to sell America with medicine and goodwill rather than bullets. Doctor Walsh has succeeded admirably, and we hope that his dream of obtaining additional ships will be fulfilled.

A special program on Medicine and Religion has been arranged for Thursday afternoon. The program will be devoted to a discussion of "The Physician's Dilemma in the World of Changing Attitudes Toward Morals."

The moderator will be the Rev. Dr. Paul B. McCleave of Chicago, Director of the American Medical Association's Department of Medicine and Religion. Other panelists will be Dr. Milford O. Rouse, the AMA President, and The Most Rev. Joseph Brunini of Jackson, Mississippi, Apostolic Administrator of the Catholic Diocese of Natchez-Jackson.

Dr. Perry E. Gresham, President of Bethany College, will be the speaker at the Centennial Banquet which will be held on Friday evening. Doctor Gresham is a close friend of the medical profession and we look forward to an inspiring address.

Dr. Richard E. Flood of Weirton, President of the State Medical Association, will deliver his presidential address at the second and final session of the House of Delegates on Saturday afternoon. When he took the oath of office last August he undoubtedly realized a most challenging year lay ahead. Many additional burdens were to be placed on the shoulders of the President during the Centennial Year. Those of us who have been in close contact with the President can report with pride that he has performed his official duties in wonderful fashion.

Doctor Flood traveled thousands of miles throughout the State and country as the representative and spokesman for the medical profession in West Virginia. In an effort to report his activities to the membership, he has incorporated in his monthly messages a running summary of his observations and recommendations. He also paid official visits to many of the county societies and on only one occasion was he unable to meet a commitment—and this was due to a blizzard. He has provided fine leadership during the Centennial Year and we are pleased that he will continue to serve the Association as Chairman of the Council during the coming year.

On Saturday afternoon Doctor Flood will turn the gavel over to another physician who has traveled extensively during the past year in behalf of the Association. Dr. Richard V. Lynch, Jr., of Clarksburg, will be elevated to the presidency following four years as a member of the Council and two years as Vice President and President Elect. He has done his homework during this time and is cognizant of the many problems facing the profession.

The members of the Womans Auxiliary have been extremely busy planning the outstanding entertainment features. An "Anniversary Ball" has been scheduled for Thursday night and the "Centennial Ball" will be held following the banquet on Friday night. A reception honoring the officers of the State Medical Association will be held on Saturday evening. Physicians, their wives, guests and representatives of our industrial exhibitors are invited to attend all of these functions.

Interest in the Exhibit Center has never been at a higher level. Every foot of space will be occupied and we urge everybody to take time out to visit both the industrial exhibits and the unusually large number of scientific exhibits. The representatives of the companies which help to make the meeting possible welcome the opportunity to discuss their products and recent therapeutic developments. Our exhibitors have been pleased with the interest of physicians in the past few years and we feel sure this will once again hold true during the Centennial Meeting.

The complete program for the meeting appears in this issue of *The Journal* and we believe you will agree the Program Committee

has succeeded in its efforts to present a program of interest to all in attendance at the Centennial Meeting.

We'll see you at The Greenbrier!

HAPPY BIRTHDAY

Medicare celebrated its first birthday on July first—it was saluted by its progenitors and identified by organized medicine as a very healthy infant, albeit a rather costly one. Statistical material makes rather dull reading, but one can only recognize the growth factors and future possibilities by citing pertinent figures.

More than nineteen million plus sixty-five citizens are enrolled under Part A, which is the hospitalization feature of Medicare. Nearly 7,200 hospitals, or 99 per cent of non-federal general care beds are approved for participation in the program. Some four million or nearly 20 per cent of eligible persons have received in-hospital services at a cost of some two and one half billions of dollars. The average daily admission is above fourteen thousand, and the average hospital stay is two days longer than in the previous year. Out-patient services have cost some twelve million dollars.

About seventeen and one half million or 93 per cent of plus 65 citizens are also enrolled under Part B, which provides medical services at usual and customary charges. The average daily patient load under Part B has been twenty six thousand and the first year's cost was six hundred forty million dollars, in addition to the deductibles of fifty dollars and 20 per cent assumed by the patient.

Mr. Wilbur J. Cohen, whose professional chromosomes and genes fused with those of a docile Congress (in this year-old child), has proudly stated that so far "no doctor has been socialized and no hospital has been regimented." It will be of some concerned interest to our colleagues to view the inexorable spread of eligibility for federally sponsored health services in the years to come. Already legislation is in the making to admit several million additional beneficiaries under the shelter of Medicare, which is now recognized as the cornerstone of the "Great Society." At the expected rate of expansion of eligibility and coverage, with a constant flux of regulations, rules and decisions, it may be certain that Mr. Cohen's sunny statement of 1967 will only be of academic interest to the healing arts in the years to come.

As was anticipated by the spokesmen for organized medicine the over-all expenditures exceed the figures given to the Congress and its committees before passage of this legislation, and one can be sure this will continue with the rising costs of hospital care; even now there is some question as to the financial soundness of the system. It has been alleged and, perhaps rightfully, that a certain number of physicians saw fit to increase their usual fees in the months that Medicare was being gestated. Organized medicine has always stated that a small percentage of physicians are careless, selfish and even dishonest in their financial relations with patients, but one must also be aware of the fact that pre-Medicare fee increases were the result of reduced fees for services rendered to the older and medically indigent patients during the years prior to Medicare.

COAL WORKERS SYMPOSIUM

The Coal Workers Symposium in Morgantown on May 18, 19, and 20 was an unqualified and outstanding medical success. This conference, under the sponsorship of the USPHS and the Appalachian Laboratories for Occupational Respiratory Disease, moderated by Dr. Charles E. Andrews, Chief of the Division of Pulmonary Diseases at West Virginia University Medical Center, aroused international interest and participation.

The symposium speakers, about 60 in all, were distinguished teachers, industrialists and Public Health authorities. To the favored few of the *hoi polloi* who were privileged to attend it was a highlight of graduate education.

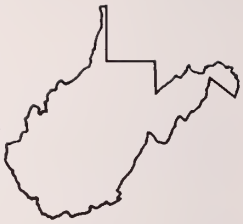
Conferences of this importance and magnitude occur rarely and accomplish a great deal to advance and extend medical knowledge. This must be the most noteworthy medical event of the Centennial year. It is hoped that the papers and remarks may eventually be put into print and made available to interested physicians.

Congratulations and felicitations to Doctor Andrews for developing this historical event in West Virginia.

'An Unwanted Event'

One of the best buys (if indeed not *the* best) in our country today is the purchase of drugs. Considering what one gets for his money, namely, better health and/or less suffering, the cost is most usually well worth every penny spent. It is most unfortunate though that many people believe quite differently. Whatever their reason may be, there frequently lies hidden that unpleasant fact of paying for an unwanted event.—Joseph P. Schaefer, in *New Physician.*

GENERAL NEWS



Distinguished Guests To Attend Centennial Meeting, Aug. 24-26

Three honor guests head a long list of distinguished physicians and surgeons who will appear as speakers at the 100th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 24-26.

Milford O. Rouse, M. D.
AMA President

Dr. Ray S. Greco of Weirton, Chairman of the Program Committee, announced that the honor guests will be Dr. Milford O. Rouse of Dallas, Texas, President of the American Medical Association; Dr. William B. Walsh of Washington, D. C., Founder, President and Medical Director of Project HOPE; and Dr. Perry E. Gresham, President of Bethany College.

Doctor Rouse was installed as President of the AMA during the annual convention in Atlantic City in June. He served for three years as Speaker of the AMA House of Delegates and, prior to that, had been Vice Speaker of the House for four years. He was named President Elect during the AMA meeting in Chicago last year. He specializes in gastroenterology and has served since 1943 as Clinical Professor of Medicine at the University of Texas Southwestern Medical School.

Doctor Rouse will be the guest speaker before the first session of the House of Delegates which will begin at 3:00 P.M. on Wednesday, August 23.

Another speaker at that session will be Dr. Blair J. Henningsgaard of Astoria, Oregon, Chairman of the Board of Directors of the American Medical Political Action Committee.

Address by Dr. William B. Walsh

Dr. William B. Walsh, who retired from active practice to organize Project HOPE, will deliver an address at the first general scientific session on Thursday morning, August 24. The session will begin at 9:00 A. M.

Doctor Walsh received his M. D. degree in 1943 from the Georgetown University School of Medicine and served for several years as Assistant Professor of Internal Medicine at Georgetown. In 1958, President Dwight D. Eisenhower asked him to Co-Chair the Committee on Medicine and the Health Professions of the President's New People-to-People Program.

Dr. Gresham to Speak at Centennial Banquet

Dr. Perry E. Gresham, President of Bethany College, will be the principal speaker at the Centennial Banquet which will be held on Friday night, August 25.

Doctor Gresham received A. B. and B. D. degrees from Texas Christian University and completed requirements for the Ph. D. degree at the University of Chicago and Columbia University.

The 1967 Program Committee

Dr. Ray S. Greco of Weirton is Chairman of the Program Committee for the 100th Annual Meeting of the West Virginia State Medical Association. Other members are: Drs. Robert Greco of Morgantown, Richard W. Corbitt of Parkersburg and Joseph D. Romino of Fairmont.

Dr. J. P. McMullen of Wellsburg is Chairman of the "Committee for 100," which planned the social and other events for the Centennial Meeting.

All physicians and their wives and children have been invited by the Program Committee to hear the addresses by Drs. Rouse, Walsh and Gresham.

Program on Medicine and Religion

A special feature of the Centennial Meeting will be a program devoted to Medicine and Religion which will feature a discussion of "The Physician's Dilemma in the World of Changing Attitudes Towards Morals."

Three experts on the relationship between the physician and the clergyman in the total care of the patient will be the participants.

The Rev. Dr. Paul B. McCleave of Chicago, Director of the American Medical Association's Department of Medicine and Religion, will serve as moderator. Other panelists will be Dr. Milford O. Rouse, President of the American Medical Association; and the Most Rev. Joseph B. Brunini of Jackson, Mississippi, Apostolic Administrator of the Catholic Diocese of Natchez-Jackson.

Presidential Address

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, will deliver his Presidential Address at the second and final session of the House of Delegates on Saturday afternoon, August 26.

Pre-Convention Meetings

In addition to the first session of the House of Delegates, there will be another important meeting prior to the formal opening of the convention on Thursday morning. A meeting of the Council of the State Medical Association will be held at 10:00 A. M. on Wednesday, August 23, and a meeting of the Cancer Committee has been scheduled for 1:30 o'clock.

The registration desk will be open in the main floor lobby from 8:30 A. M. to 5:00 P. M. each day during the convention.

General Scientific Sessions

The three general scientific sessions will be held in Governor's Hall in the West Virginia Wing. Several of the afternoon meetings of sections and affiliated societies also will be held in Governor's Hall and the nearby Mountaineer Room, while other meetings will be held in the Convention Unit.

Industrial and scientific exhibits will be housed in the Exhibit Center in the West Virginia Wing just outside Governor's Hall and the Mountaineer Room.

Scientific Motion Pictures

Dr. John J. Mahood of Bluefield is Chairman of the Committee arranging the scientific motion picture program during the three-day meeting. Sound motion pictures on scientific subjects will be shown in Governor's Hall on Thursday, Friday and Saturday mornings prior to the opening of each general session.

Luncheon for Past Presidents

A luncheon honoring past presidents of the West Virginia State Medical Association will be held at The Greenbrier on Thursday, August 24, during the 100th Annual Meeting.

Dr. Seigle W. Parks of Charleston, Immediate Past President, will preside. Twenty-five past presidents have been invited to attend the luncheon.

Richard V. Lynch, Jr., M. D.
President Elect

Formal Opening of Convention

Doctor Greco will call the Centennial Meeting to order at 9:00 A. M. on Thursday in Governor's Hall. Doctor Flood will deliver the address of welcome and the first speaker on the program will be Doctor Walsh. Doctor Greco and Dr. Joseph D. Romino of Fairmont will serve as moderators for the scientific portion of the program. The guest speakers and their subjects are:

Brian Blades, M. D., Lewis Saltz Professor of Surgery and Chairman, Department of Surgery, George Washington University School of Medicine, Washington, D. C. Subject: "The Management of Severe Trauma."

John C. Ullery, M. D., Professor and Chairman, Department of Obstetrics and Gynecology, Ohio State University College of Medicine, Columbus. Subject: "Advances in the Use of Progestagens (The Pill)."

Thursday Afternoon Program

In addition to the program on Medicine and Religion on Thursday afternoon, several meetings have been scheduled later in the afternoon. Dr. Maynard P. Pride of Morgantown will preside at a meeting of the Resolutions Committee which will be held at 3:30 o'clock and Dr. Albert C. Esposito of Huntington will preside at a meeting of the Committee on Nominations at 5 o'clock.

Allergy Meeting on Thursday Afternoon

Seven out-of-state physicians will present papers at a meeting of the West Virginia State Society of

William B. Walsh, M. D.

Allergy which will be held on Thursday afternoon at 3:30 o'clock. Dr. Robert H. Mutch of Fairmont will preside.

Dr. Merle S. Scherr of Charleston will serve as moderator and the speakers and their topics are as follows:

Dr. Howard G. Rapaport of New York City, President of the American College of Allergists, who will bring greetings from the College as well as discuss "Practical Allergy in General Medicine Today."

Dr. Bernard Berman, Brookline, Massachusetts. Subject: "Advances in Pediatric Allergy."

Dr. Philip Blank, Pittsburgh. Subject: "Urticaria, Migraine, Insect and Miscellaneous Allergies."

Dr. Irvin Caplin, Indianapolis, Indiana. Subject: Bronchial Asthma and Its Management."

Dr. Joseph H. Fries, New Hyde Park, New York. Subject: "Management of Food Allergy."

Dr. Mayer A. Green, Pittsburgh. Subject: "Nasal Allergy and Its Management."

Dr. A. Harvey Neidorff, Altoona, Pennsylvania. Subject: "Allergic Contact and Atopic Dermatitis."

Second General Session
Friday Morning

Drs. Richard W. Corbitt of Parkersburg and Robert Greco of Morgantown will serve as moderators for the second general scientific session on Friday morning, August 25. The speakers and their subjects are as follows:

Charles A. Doan, M. D., Dean Emeritus, Ohio State University College of Medicine, Columbus. Subject: "Progress in the Control of the Leukemias and Lymphomata."

Convention Timetable

The first general scientific session will begin at 9 A.M. on Thursday, August 24. The Friday and Saturday sessions will begin at 9:30 A.M.

The first session of the House of Delegates will be on Wednesday afternoon, August 23, beginning at 3 P.M. The second session will be on Saturday afternoon beginning at 2:30 P.M.

The Exhibit Center will be open from 8:30 A.M. to 3:30 P.M. on Thursday and Friday and from 8:30 A.M. to 1 P.M. on Saturday.

John K. Lattimer, M. D., Professor and Chairman of the Department of Urology, College of Physicians and Surgeons of Columbia University, and Director of the Squier Urological Clinic, New York City. Subject: "Prostatic Cancer: New Findings Through the Electron Microscope, Tissue Culture and Time Lapse Photography."

Dana L. Farnsworth, M. D., Henry K. Oliver Professor of Hygiene and Director of University Health Services, Harvard University. Subject: "The Drug Problem Among Young People."

Friday Afternoon Program

The sections and societies affiliated with the State Medical Association will conduct scientific and business sessions beginning at 2:00 P. M. on Friday.

Dr. George A. Curry of Morgantown will preside at a meeting of the Section on Internal Medicine and the speaker will be Dr. Charles A. Doan. His subject will be "Some New Therapeutic Advances of Significance to the Internist."

Drs. John K. Lattimer and Clark D. West will present papers before a joint meeting of the Sections on Pediatrics and Urology. Doctor Lattimer will discuss "Physiological Testing and the Problem of Reflux in Children," and Doctor West's subject will be "Medical Therapy of Chronic Urinary Tract Infection in Children."

Dr. W. Alva Deardorff of Charleston will preside at a meeting of the West Virginia Radiological Society. Dr. Andrew K. Poznanski of Detroit will present a paper on "Breast Radiography: Pathologic—Radiologic Correlation."

Dr. Norman W. B. Craythorne of Morgantown will preside at a meeting of the West Virginia Society of Anesthesiologists. The speaker will be Dr. Paul E.

House of Delegates To Meet Twice During Meeting

The first session of the House of Delegates during the Annual Meeting at The Greenbrier will be convened at 3 P.M. on Wednesday, August 23. The second and final session of the House of Delegates will be held at 2:30 P.M. on Saturday, August 26.

Huffington of Easton, Maryland, and his subject will be "The Law and Doctor Jones."

Dr. Dana L. Farnsworth will discuss "Community Mental Health Centers— Progress and Problems," before a meeting of the Section on Neurology, Neurosurgery and Psychiatry. Dr. David M. Wayne of Bluefield will preside.

Dr. Ray E. Burger of Welch will preside at a meeting of the Section on Surgery. The speaker will be Dr. Brian Blades and his subject will be "The Surgical Treatment of Metastatic Lung Tumors."

Dr. Daniel A. Mairs of Charleston will preside at a meeting of the West Virginia Obstetrical and Gynecological Society. The speaker will be Dr. John C. Ullery and his subject will be "The Management of Operative Urinary Tract Injuries."

Dr. Paul A. Kelley of Ann Arbor, Michigan, will present a paper on "The Surgical Treatment of Ankylosing Spondylitis" before a meeting of the Section on Orthopedic Surgery. Dr. Thomas F. Scott of Huntington will preside.

Meeting at 3:00 P. M. will be the West Virginia Chapter, American Society of Internal Medicine, with Dr. Jack H. Baur, presiding.

Dr. William C. Morgan of Charleston will preside at a meeting of the West Virginia Society of Ophthalmology and Otolaryngology at 4:00 P. M.

Third General Session
Saturday Morning

The third and final general scientific session on Saturday morning will be devoted to a program honoring Dr. Edward J. Van Liere, Dean Emeritus of the West Virginia University School of Medicine.

The Van Liere-University Day Program will have as its theme, "Medical Education—Past, Current and Future." Dean Clark K. Sleeth will serve as moderator and the other participants will be the deans of six medical schools with whom Doctor Van Liere has been associated for many years:

Kenneth R. Crispell, M. D., Dean, The University of Virginia Medical School.

Charles A. Doan, M. D., Dean Emeritus, Ohio State University School of Medicine.

Kinloch Nelson, M. D., Dean, Medical College of Virginia.

John Parks, M. D., Dean, The George Washington University School of Medicine.

William A. Sodeman, M. D., Dean Emeritus, Jefferson Medical College of Philadelphia.

William S. Stone, M. D., Dean, University of Maryland School of Medicine.

Saturday Afternoon Meetings

The West Virginia Association of Pathologists will conduct a business meeting at 1:30 o'clock on Saturday afternoon. Dr. Peter Ladewig of Charleston will preside.

Second Session of the House of Delegates

The second and final session of the House of Delegates will be held on Saturday afternoon beginning at 2:30 o'clock. Doctor Flood will preside and the session will feature Doctor Floods' Presidential Address

Dr. Perry E. Gresham

and the installation of Dr. Richard V. Lynch, Jr., of Clarksburg as President of the State Medical Association. Other officers for 1967-68 also will be elected and installed.

A check representing physician contributions to the WVU School of Medicine through the AMA-ERF pro-

Nominating Committee To Meet On Thursday, August 24

The Committee on Nominations of the State Medical Association will meet at 5 P.M. on Thursday, August 24, during the Annual Meeting at The Greenbrier.

The Committee will consider and recommend to the House of Delegates prior to the election of officers, at its final session, nominees for the offices of President Elect, Vice President, Treasurer, and the American Medical Association Delegate and Alternate.

Dr. Albert C. Esposito of Huntington will serve as Chairman. Other members of the Committee were elected at the Spring Meeting of the Council, and they are as follows: Drs. G. Thomas Evans of Fairmont (1st District); Maynard P. Pride of Morgantown (2nd District); Andrew J. Weaver of Clarksburg (3rd District); I. Ewen Taylor of Huntington (4th District); A. J. Villani of Welch (5th District); and W. P. Bittinger of Oak Hill (6th District).

The By-Laws of the Association also specify that nominations may be made from the floor for the various offices.

gram will be presented to Dr. Clark K. Sleeth, Dean of the School of Medicine.

Medical School Alumni Parties

The Alumni Associations of two medical schools will hold cocktail parties in connection with the meeting.

The West Virginia Chapter of the Medical College of Virginia Alumni Association will hold a cocktail party on Thursday evening at 6:30 o'clock. Dr. W. Alva Deardorff of Charleston is in charge of arrangements.

Another cocktail party will be held on Friday evening at 6:00 o'clock by the University of Virginia Alumni Fund—Medical Division. Dr. James P. Baker of White Sulphur Springs is in charge of arrangements.

Representatives of both schools have indicated that several administrative officials plan to be in attendance.

Auxiliary Dance on Thursday Evening

An Anniversary Ball, arranged by the Woman's Auxiliary to the Raleigh County Medical Society, will be held on Thursday evening beginning at nine o'clock.

Centennial Banquet and Ball

The Centennial Banquet and Ball will be held in Chesapeake Hall on Friday night, beginning at 7:30 o'clock. The Banquet will be preceded by a cocktail party at 6:30 o'clock.

The principal speaker at the Banquet will be Dr. Perry E. Gresham, President of Bethany College.

Cocktail Party on Saturday Evening

A cocktail party and reception honoring the officers of the West Virginia State Medical Association will be held on the Chesapeake Hall Terrace on Saturday evening from 6:30 to 7:30 o'clock. All members of the Association and the Auxiliary, their families, representatives of the industrial and scientific exhibits and guests are invited to attend.

Prizes to the winners of the annual Medical Golf Tournament will be awarded at that time.

Industrial and Scientific Exhibits

Physicians, members of the Auxiliary and guests are invited to visit the more than 50 informative industrial and scientific exhibits which will be housed in the Exhibit Center throughout the meeting. The exhibits will be open each day from 8:30 A. M. to 3:30 P. M.

Heavy Registration

The number of reservations for rooms at The Greenbrier during the Annual Meeting has passed the 650 mark. More than 800 persons are expected to be in attendance.

No Convention Registration Fee

No registration fee will be assessed against either members or guests in connection with the 100th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 24-26, 1967.

Motion Picture Schedule

Dr. John J. Mahood of Bluefield, Chairman of the Motion Picture Program for the Annual Meeting at The Greenbrier, has announced the schedule of movies which will be shown in Governor's Hall each morning prior to the general scientific sessions.

Thursday—"Non-Syphilitic Venereal Diseases" and "Management of Mass Casualties."

Friday—"Technical Procedures for Diagnosis and Therapy in Children" and "Dynamics of Tumor Embolism."

Saturday—"Chronic Bronchitis" and "Reprieve from Lethal Infection."

Action Due in August on Proposed Constitutional Amendments

Several amendments to the Constitution of the West Virginia State Medical Association, offered at the 99th Annual Meeting in White Sulphur Springs, August 25-27, 1966, will be acted upon finally by the House of Delegates at the 100th Annual Meeting at The Greenbrier, August 24-26, 1967.

The proposed amendments follow:

Article IX

Amend Article IX, Section 1, line 3, by deleting the word, "twelve," and substituting therefor the word, "fourteen."

Amend Article IX, Section 2, line 4, by deleting the words, "each year," and substituting therefor the words "every second year as shall be provided for in the By-Laws for reapportionment of Councilor Districts."

Amend Article IX, Section 2, paragraph 3, line 4, by adding, "except as provided in the By-Laws pertinent to reapportionment of Councilor Districts."

AMA Aces and Deuces Group Re-Elects Doctor Holroyd

Dr. Frank J. Holroyd of Princeton was elected to his ninth consecutive term as Secretary-Treasurer of the Aces and Deuces organization at the annual breakfast meeting held at the Hotel Chalfonte in Atlantic City, New Jersey, during the American Medical Association convention.

Dr. George D. Johnson of Spartanburg, South Carolina, was elected President, succeeding Dr. Leslie A. Moren of Elko, Nevada.

Aces and Deuces is a social organization composed of delegates and alternate delegates to the American Medical Association from states which have one or two AMA delegates.

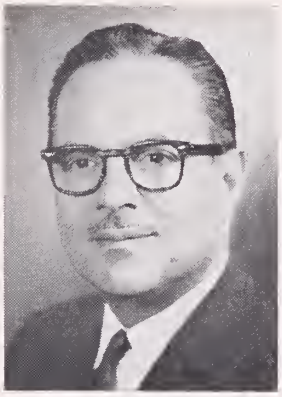
An Aces and Deuces luncheon honoring AMA officers and members of the House of Delegates will be held during the AMA Clinical Convention in Houston, Texas, in November.

A Salute to the Living Presidents of the West Virginia State Medical Association

Of the 101 men who have served as President of the West Virginia State Medical Association, 26 are still living and many of them remain active in the affairs of our organization. The editors of *The Journal* feel it appropriate to salute these men in this special section as the 100th Annual Meeting of the West Virginia State Medical Association draws near.

Richard E. Flood, M. D.
Weirton
1966-67

Seigle W. Parks, M. D.
Charleston
1965-66



Albert C. Esposito, M. D.
Huntington
1964-65

L. J. Pace, M D.
Princeton
1962-63

D. E. Greeneltch, M. D.
Wheeling
1961-62

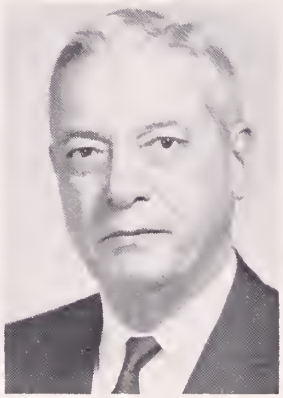
John W. Hash, M. D.
Charleston
1960-61

J. C. Huffman, M. D.
Buckhannon
1959-60

George F. Evans, M. D.
Clarksburg
1958-59

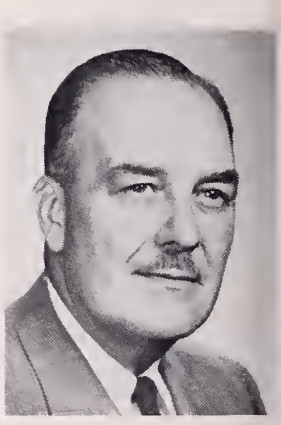
C. A. Hoffman, M. D.
Huntington
1957-58

E. Lyle Gage, M. D.
Bluefield
1957



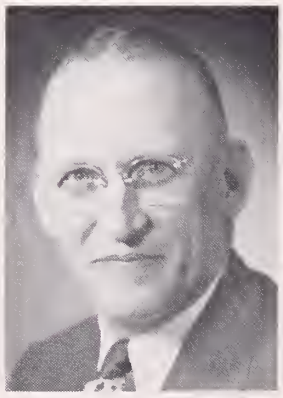
Athey R. Lutz, M. D.
Parkersburg
1956

James P. McMullen, M. D.
Wellsburg
1955

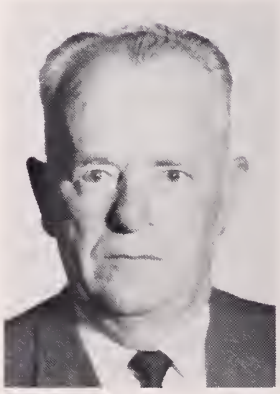


Russel Kessel, M. D.
Charleston
1954

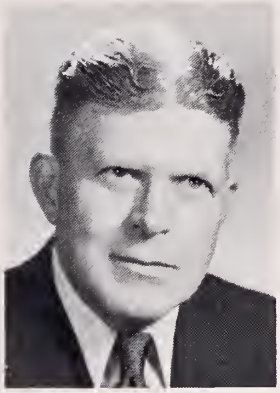
James S. Klumpp, M. D.
Huntington
1953



Sobisca S. Hall, M. D.
Clarksburg
1952



Frank J. Holroyd, M. D.
Princeton
1951



Thomas G. Reed, M. D.
Charleston
1949

Andrew E. Amick, M. D.
Lewisburg
1946

Thomas L. Harris, M. D.
Parkersburg
1945

Robert J. Reed, Jr., M. D.
Wheeling
1944

Frank V. Langfitt, M. D.
Clarksburg
1940

Ray M. Bobbitt, M. D.
Huntington
1939

Charles G. Morgan, M. D.
Corpus Christi, Texas
1936

D. A. MacGregor, M. D.
Wheeling
1933

B. A. Ashworth, M. D.
Moundsville
1924

J. H. Anderson, M. D.
Hemphill
1921

California Physician Named AMA President Elect

Dr. Dwight L. Wilbur, a 63-year-old San Francisco internist and gastroenterologist, has been named President Elect of the American Medical Association.

Dwight L. Wilbur, M. D.

When he is installed as President at the AMA convention in his home city next June, it will mark the first time in the AMA's long history that a son has assumed the same presidency once held by his father. Doctor Wilbur is the son of the late Ray Lyman Wilbur, the AMA's 76th President, who served in 1923-24.

The elder Doctor Wilbur also served as Secretary of the Interior under President Herbert Hoover and as President and Chancellor of Stanford University. The son will be the AMA's 123rd President.

Dr. Dwight L. Wilbur was named President Elect at the AMA meeting in Atlantic City, New Jersey, on Wednesday, June 21. He has served on the Board of Trustees since June, 1963.

A native of England, Doctor Wilbur earned his M. D. degree at the University of Pennsylvania in 1926, after which he was associated with the Division of Medicine of the Mayo Clinic.

During World War II, he served at the U. S. Naval Hospital in Oakland, California, with the Rank of Commander. Since 1949, he has been clinical professor of medicine at Stanford University School of Medicine.

Doctor Wilbur is Chief of Medical Service at French Hospital in San Francisco. Since 1946, he has served as Editor of *California Medicine*, the journal of the California Medical Association. He is also Chairman of the Editorial Board of *Gastroenterology*.

He is a Diplomate of the American Board of Internal Medicine and the National Board of Medical Examiners, and a Past President of both the American Gastroenterological Association and the American College of Physicians.

From 1951 until his election to the AMA Board of Trustees, Doctor Wilbur was a Delegate to the AMA from the California Medical Association.

Doctor Hamaty Named ACP Fellow

Dr. Daniel Hamaty of Charleston was elected a Fellow of the American College of Physicians on April 9. Doctor Hamaty is a rheumatologist and is Director of Medical Education at Charleston Memorial Hospital.

Dr. Brown Shoots for Fourth Medical Golf Crown

Dr. Robert R. Brown of Romney will be the defending champion when play gets under way in the annual Medical Golf Tournament, a recreational feature of the Centennial Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 24-26.

Doctor Brown shot a 70 last year to win his third Medical Golf Title and gain permanent possession of a beautiful trophy sponsored by Hospital and Physicians Supply Company of Charleston. He also won the tournament in 1965.

Another expert golfer who no doubt will compete again this year is Dr. Joseph T. Mallamo of Fairmont, himself a seven-time winner of the crown. Doctor Mallamo finished as runner-up to Doctor Brown the last two years.

The best low gross scorers last year were: Doctor Brown, 70; Doctor Mallamo, 71; Dr. J. P. Aliff of Charleston, 77; Dr. F. W. Mallamo of Fairmont, 78; and Dr. C. Stafford Clay of Huntington, 79.

Dr. Joseph A. Smith of Dunbar, Chairman of the Golf Committee, said that physicians participating in this year's tournament will pay an entrance fee of $5, payable at the time they register to play in the tournament. There will be several prizes in addition to the championship trophy.

Physicians may participate in tournament play both mornings and afternoons during the three-day meeting. Participants are to inform the starter when they begin their official tournament round. All tournament play must be completed by 4 P.M. on Saturday, August 26.

Grant for Raleigh Program Approved by OEO

The federal Office of Economic Opportunity has approved a grant of $987,085 for the Raleigh County Community Action Association's comprehensive health program.

The project, expected to be in full operation by late fall or early winter, will employ about 200 people. A non-profit corporation called The Mountaineer Family Health Plan, Inc., has been set up to handle the project.

The program for low income groups will offer complete medical services and limited dental work through a main center at Beckley Appalachian Regional Hospital and several branches. The income limitation for a family of four under the program is $3,000 a year. An additional $500 is allowed for each additional family member.

Plans for the first year of the project call for employment of six fulltime physicians, health officers, a health projects coordinator, a medical records clerk, health aides and ambulance personnel.

Dr. Sherl J. Winter of Beckley is Director of the program.

Annual Medical Seminar Planned In Bluefield on Oct. 12

Four physicians will present papers at the annual Seminar sponsored by the Bluefield Sanitarium, which will be held at the Bluefield Country Club on October 12. The Seminar is sponsored jointly by the Bluefield Sanitarium, Stevens Clinic Hospital in Welch and the Clinch Valley Clinic in Richlands, Virginia.

The following out-of-state physicians will present papers at the one-day session:

Dr. David M. Hume, Chairman of the Department of Surgery at the Medical College of Virginia in Richmond.

Dr. J. Graham Smith, Jr.. Professor and Chairman of the Department of Dermatology at the Medical College of Georgia in Augusta.

Dr. Robert F. Heimburger, Chairman of the Department of Neurosurgery at the Indiana University Medical Center.

Dr. R. O. Rogers, Jr., of the Department of Internal Medicine at the Bluefield Sanitarium, also will present a paper.

Dr. Charles D. Pruett, Chairman of the Seminar Committee, announced that the scientific session will be held in the afternoon and there will be a banquet that evening. The name of the speaker will be announced at a later date.

Professional Tax Challenged In Cabell Court

The medical, dental and legal professions in Cabell County have gone to court in an effort to overthrow a tax on professional incomes enacted by the Huntington City Council.

Plaintiffs in the action, in Cabell County Circuit Court, are the Cabell County Medical Society, the Cabell County Bar Association and the Huntington Dental Society.

Counsel for the three organizations said the city ordinance adopted on April 11 was illegal because the Legislature did not authorize an extension of the power to levy a gross sales tax on professional incomes. The Legislature enacted a state tax of this nature earlier this year.

Huntington City Council estimated that the local tax, 80 cents on every $100 of business, would yield about $80,000 a year.

Training in Radiology Available

The Allegheny General Hospital in Pittsburgh has announced that there are positions open to physicians for training in radiation therapy leading to board certification.

Positions are open to physicians in general practice and to physicians with training in internal medicine, pathology and allied specialties. Salary commensurate with number of dependents, age and experience.

Interested physicians should contact Dr. John C. Frich, Jr., Department of Radiation, Allegheny General Hospital, Pittsburgh, Pennsylvania 15212.

Several Physicians Appointed To State Boards

Gov. Hulett C. Smith recently appointed several West Virginia physicians to various state government boards and commissions for terms that began on July 1.

Dr. Frank J. Holroyd of Princeton was reappointed to the Medical Licensing Board for a term ending June 30, 1972. Doctor Holroyd has been serving as Chairman of the Board. Also reappointed to the Licensing Board was Dr. Darrel Darby of Huntington, one of two podiatrist members.

Dr. Hu C. Myers of Philippi was reappointed to the State Board of Health for a term ending in 1976, and Dr. L. J. Pace of Princeton was appointed to the new State Board of Examniers for Licensed Practical Nurses for a term ending in 1970.

State Health Director N. H. Dyer was appointed to the Ohio-West Virginia Interstate Air Pollution Control Commission. The appointment, effective June 6, will extend to the end of Doctor Dyer's tenure as Health Director.

The Governor made two appointments to the Commission on Postmortem examinations, which is chaired by Dr. Richard W. Corbitt of Parkersburg. Dr. Earl C. Hahn of St. Marys, an osteopath, will serve until June 30, 1971.

Also appointed to the Commission was State Police Maj. W. L. Pike of Elkview, whose term will run to June 30, 1973. Major Pike replaces T. A. Welty of Charleston, who recently was promoted to Superintendent of the Department of Public Safety (State Police). Colonel Welty had been the Commission's Vice Chairman.

State and Hancock Auxiliaries Win AMA-ERF Honors

The Woman's Auxiliary to the West Virginia State Medical Association and one of its components were cited for their outstanding support of AMA-ERF during the Convention of the Woman's Auxiliary to the American Medical Association which was held in Atlantic City in June.

The State Auxiliary gave $14,928.49 to AMA-ERF during 1966-67. This amount was the greatest contribution of any state group in the 1,001 to 1,500 member category, and the Auxiliary received an award of merit for its achievement.

A special national achievement award was presented to the 22-member Woman's Auxiliary to the Hancock County Medical Society. The Hancock unit raised $4,676 for a per capita contribution of $212.57, the largest in the nation.

Also at the AMA Auxiliary Convention, Mrs. Wilson P. Smith of Huntington, a Past President of the Auxiliary to the West Virginia State Medical Association, was installed as National Eastern Regional Chairman of AMA-ERF. Her territory will include 14 states from Maine to Virginia.

Mrs. M. Bruce Martin of Huntington served as State AMA-ERF Chairman during the past year.

Dr. Milford O. Rouse Installed As AMA President

Dr. Milford O. Rouse of Dallas, Texas, was installed as President of the American Medical Association during the AMA's 116th Annual Convention in Atlantic City, New Jersey, June 18-22.

The inaugural ceremony on Tuesday, June 20, was one of the highlights of the meeting, which was attended by several thousand physicians, members of their families, exhibitors and other guests. Doctor Rouse succeeded Dr. Charles L. Hudson of Cleveland, Ohio.

Doctor Wilbur President Elect

The AMA's new President Elect is Dr. Dwight L. Wilbur of San Francisco, California, the son of a former AMA President (see biographical sketch elsewhere in this issue of *The Journal*). Like Doctor Rouse, he is a gastroenterologist. He will be installed as President at the AMA meeting in his home city next June.

Dr. Malcom E. Phelps of El Reno, Oklahoma, was elected Vice President of the AMA. He has been serving as field director of the Volunteer Physicians for Viet Nam Program.

Dr. Walter C. Bornemeier of Chicago was re-elected Speaker of the House of Delegates, as was Dr. Russell B. Roth of Erie, Pennsylvania, the Vice Speaker.

Election of Trustees

Dr. Edward R. Annis of Miami, Florida, a Past President of the AMA, was elected to complete a term on the Board of Trustees. He succeeds the late Dr. Homer L. Pearson, also of Miami.

Another new Trustee is Dr. Burt L. Davis of Palo Alto, California, who was elected to the position previously held by Doctor Wilbur, the new President Elect.

Four trustees were re-elected. They are: Drs. Wesley W. Hall of Reno, Nevada, Chairman of the Board; Irvin E. Hendryson of Denver, Colorado; Alvin J. Ingram of Memphis, Tennessee; and Robert C. Long of Louisville, Kentucky.

Resolutions and Reports

The AMA's policy-making House of Delegates was confronted with a variety of business, including a record total of 123 resolutions from the state medical associations and several reports from the Board of Trustees and the various Councils of the AMA. The House acted on such matters as therapeutic abortion, Appalachian regional health programs, medicine and osteopathy, and the AMA Members' Disability Insurance Program.

Appalachian Health Program

The West Virginia State Medical Association sponsored a resolution embodying a proposed statement of policy of the AMA toward health projects undertaken through the Appalachian Regional Development Act of 1965. While the House did not specifically adopt the West Virginia resolution, it did approve a statement that contained essentially the same principles.

The statement, as adopted, provides for the following guidelines for Appalachian health programs: demonstrated need for the proposed project; local control; participation of a significant proportion of local physicians in planning and development of the project; the operation of any regional, area or county health service facility shall not infringe on the private practice of medicine; all health services shall be rendered at a cost to the patient commensurate with his social and economic status; there shall be adequate medical representation on all national, state and local bodies having supervision or jurisdiction in the development and/or operation of such health service facilities; and these health service projects shall in no way be developed, operated or influenced in any manner which could lead to a government-controlled system of medical practice.

Therapeutic Abortion

The AMA modernized its policy on therapeutic abortion, liberalizing a statement which had been in effect since 1871. The following was established as policy of the AMA:

". . . Recognizing that there are many physicians who, on moral or religious grounds, oppose therapeutic abortion under any circumstances, the American Medical Association is opposed to induced abortion except when:

"(1) There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother, or

"(2) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or

"(3) There is documented medical evidence that continuance of a pregnancy, resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient;

"(4) Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing; and

"(5) The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

"It is to be considered consistent with the principles of ethics of the American Medical Association for physicians to provide medical information to State Legislatures in their consideration of revision and/or the development of new legislation regarding therapeutic abortion."

Disability Insurance Program

A large crowd gathered to hear testimony, before a Reference Committee of the House, concerning the AMA Members' Disability Insurance Program.

The Committee's report, as adopted by the House of Delegates, recommended that the Board of Trustees be authorized to make every effort to continue the Disability Program with the same premium-benefit structure. It also recommended several guidelines to aid the Board in negotiating and executing the necessary contracts and in the future operation of the program.

Among these guidelines were recommendations that the contract should provide ample assurance that

disability claimants be treated equitably and justly, and that the carrier should guarantee benefits and premiums for at least five years.

Medicine and Osteopathy

The House considered anew the relationship between doctors of medicine and doctors of osteopathy. Several recommendations adopted by the House included one authorizing the Board of Trustees to begin negotiations directed toward officially changing schools of osteopathy to schools of medicine. Also, the Council on Medical Education was authorized to undertake negotiations to establish means by which selected students with proven satisfactory scholastic ability in schools of osteopathy may be considered for transfer to medical school classes.

Remarks by Doctor Hudson

Doctor Hudson, the retiring President, presented his presidential address before the opening session of the House of Delegates on Sunday, June 18.

He urged American physicians to "take the initiative and apply local solutions to local problems" in order to "persuade people that the proper function of government is to confine its activities to the support of private enterprise rather than to act as a competitor."

Doctor Rouse's Address

Two days later, at his inauguration, Doctor Rouse followed a similar theme in pointing out that "the Federal Government is making its moves into areas where, to its own satisfaction at least, it is able to demonstrate unfilled needs for health care or health care planning."

"If we are alert to our responsibilities for filling all of the apparent vacuums in communitywide health programs," he said, "we can eliminate areas which may seem to demand government involvement."

State Medicare Eligibility Reaches 190,500

After more than one year of Medicare, approximately 190,500 West Virginians are eligible for benefits under the health program.

"The program started on time and has worked well from the beginning," Mr. V. T. Handley, Clarksburg District Manager of Social Security, recently told The Clarksburg Telegram.

Eighty-six hospitals and 22 extended care facilities, with a total of 13,800 beds, are now participating in the program.

Mr. Handley said there has been a 15 to 20 per cent increase in utilization of in-patient service by older people, but this represents less than five per cent increase in total utilization of facilities.

West Virginia hospitals have processed 58,600 admissions under Medicare, accounting for more than $18.5 million in claims payments.

There are 178,700 West Virginians enrolled for Supplementary Medical Insurance (Part B), and benefits paid to West Virginians under this part of Medicare during the past year was more than $4.3 million.

Education Committee Arranges First PG Course

The West Virginia State Medical Association will sponsor its first postgraduate medical education course on Saturday, September 9, under the auspices of the Committee on Medical Education and Hospitals.

Dr. Pat A. Tuckwiller of Charleston, Chairman of the Committee, announced that a course entitled "Cardiac Auscultation Review with Case Presentations" will be conducted at Herbert J. Thomas Hospital in South Charleston beginning at 9:30 A.M.

Dr. D. Sheffer Clark of Huntington is in charge of presenting the program. Also invited to appear with Doctor Clark are Dr. William S. Sheils of Huntington and Dr. Robert J. Marshall, Professor of Medicine and Chairman of the Division of Cardiology at the West Virginia University Medical Center.

Several cardiologists and internists from the Charleston area have been invited to participate as discussants.

The course was arranged in cooperation with Cabell-Huntington Hospital, the Cabell-Wayne Heart Association and the State Health Department. Dr. Edwin M. Shepherd of Charleston is serving as the Committee's coordinator for the course.

Registration is limited to 60 physicians, and the registration fee of $5 will include luncheon at the hospital. Fees will be waived for medical students, interns and residents.

Application has been made to the American Academy of General Practice for accreditation of the course.

Several patients with a variety of cardiac conditions will be presented in person. Through the use of special equipment, the course enrollees will be able to listen to the heart sounds, and the clinicians will discuss the individual cases.

Detailed information and an advance registration form appear elsewhere in this issue of *The Journal.*

For purposes of administration, the Committee divided the State into eight geographical areas with one member of the Committee serving as the Educational Coordinator in each region. While the first course was arranged for Area 5 (Charleston and vicinity), Doctor Tuckwiller stressed that physicians in other sections of the State are not only invited but encouraged to attend the program.

Doctor Tuckwiller expressed the hope that at least one program can be conducted in each of the other seven areas during 1967-68.

Family Planning Workshop Slated at WVU

A Workshop in Family Planning will be conducted at the West Virginia University Medical Center on September 20.

There will be no charge for the workshop, which is sponsored by the Department of Obstetrics and Gynecology. Registration will be limited to 20 persons.

Additional information may be obtained by writing to the Department of Obstetrics and Gynecology, West Virginia University Medical Center, Morgantown, West Virginia 26506.

Health Department Outlines Hospital Program

In a recent issue of the "State of the State's Health," State Health Director N. H. Dyer turned his attention to the Public Health Service's new emergency hospital program.

The health official explained that an interagency Task Force appointed in August 1965 to analyze the current program administered by the Public Health Service, and where indicated, to restate policies and provide new directions for improving the operational readiness for emergency use of medical stockpile materials had produced several recommendations to improve the emergency hospital program and noted that state and community hospitals are showing a willingness to participate in two of these recommendations involving new programs for augmenting the hospital's capabilities in time of emergency.

"Packaged Disaster Hospitals now stored throughout the nation and in our State will be brought into operational affiliation with existing community hospitals, and an additional 30-day back-up supply of critical medical items necessary for emergency care will be placed in those hospitals taking part in the program," Doctor Dyer said. He mentioned that 42 states, including West Virginia, had given final approval of the program.

In discussing the selection of candidate hospitals for participation in the prepositioning of Packaged Disaster Hospitals and the 30-day back-up supply known as the Hospital Reserve Disaster Inventory (HRDI Unit), called the "HARDY" Program, Doctor Dyer said priority is given to those hospitals near areas of high casualty expectation. He also said that the size of the hospital and its vulnerability to attack are also considered.

For a hospital to be eligible this year for Packaged Disaster affiliation or participation in the Hospital Reserve Disaster Inventory Program, Doctor Dyer stated, it should have at least 50 beds and must be located within 50 miles of the central city in an area having a population of 250,000 or more. In addition, he pointed out, the vulnerability of each hospital has been determined by a federal study and only those hospitals with a reasonable chance of surviving the effects of nuclear attack are eligible.

Doctor Dyer noted that West Virginia has 11 candidate hospitals located at Beckley, Logan, Man, Montgomery, Oak Hill, Spencer, and Williamson which qualify for participation in the new program. All candidate hospitals which qualify for participation will be contacted by the program consultant of the Office of Health Mobilization, State Department of Health, which administers the program, he explained.

As the programs progress and as funds become available, supplementary lists of hospitals will be developed, the health official said. He explained that the eventual goal of the Public Health Service is to have every Packaged Disaster Hospital in the state affiliated with a community hospital. It is anticipated that eventually every hospital in the country will be eligible to participate in the Hospital Reserve Disaster Inventory Program.

Doctor Dyer pointed out that 16 Packaged Disaster Hospitals are located in our State in Martinsburg, Madison, Lewisburg, Pughtown, Clarksburg, Shepherdstown, Kanawha City, Institute, Fairmont, Point Pleasant, Welch, Princeton, Morgantown, Triadelphia, Skelton, and Parkersburg. He said that every Packaged Disaster Hospital will eventually be refurbished and valued at $40,000.

State Medical Association Lists Names of New Members

The following is a list by component societies of new members of the West Virginia State Medical Association elected since January 1, 1967:

Barbour-Randolph-Tucker

Carhart, James Milton ..... Philippi

Cabell

Craycraft, L. B. ..... Kenova
Lilly, James A. ..... Huntington
Miller, C. Dudley ..... "
Weaver, Oscar M., Jr. ..... "

Fayette

Bautista, A. R. ..... Montgomery

Greenbrier Valley

Julias, G. S. ..... White Sulphur Springs
Yeager, John J. ..... " " "

Hancock

Edelstein, Joseph M. ..... Weirton
Yurko, Anthony A., Jr. ..... "

Harrison

Hess, David Rae ..... Bridgeport
Spencer, Frederick A. ..... Salem

Kanawha

Celis, Jose A. ..... Charleston
Curnutte, Larry D. ..... "
Gimenez, E. E. ..... "
Sherrill, Gene D. ..... "

Marion

Gardner, Robert J. ..... Fairmont
Hunter, Murry B. ..... "
Jones, R. H., Jr. ..... "

Mason

Grubb. John M. ..... Pt. Pleasant

McDowell

Hansen, Robert W. ..... Welch

Mingo

Simmons, William C. ..... Gilbert
Walker, Paul E. ..... Williamson

Monongalia

Bowers, K. D., Jr. ..... Morgantown

Ohio

Bowman, H. T., Jr. ..... Wheeling
Franklin, Norman ..... "
Holtrop, H. R. ..... "
Ritz, T. L. ..... "
Trapp, D. C. ..... "
Weiler, Robert R. ..... "

Parkersburg Academy

Messenger, Karl H. ..... Parkersburg
Vasquez, J. G. ..... Grantsville

Potomac Valley

Liebig, Carl A. ..... Keyser
Roberts, Robert Ellis ..... Petersburg

Raleigh

Ahmed, M. Jamil ..... Beckley
Campa, Jose C. ..... "

Research Support Applications Sought by Heart Assn.

The American Heart Association is now accepting applications from research investigators for support of studies during the year beginning next July 1.

The deadline for applications for established investigatorships, advanced research fellowships, visiting scientists and British-American research fellowships is September 15. Cut-off for applications for grants-in-aid is November 1.

Application forms for awards in any of these categories may be obtained from the Director of Research, American Heart Association, 44 East 23rd Street, New York City, New York 10010; or from the West Virginia Heart Association, 759 West Washington Street, Charleston, West Virginia 25302.

Mrs. Long Named President Elect Of AMA Auxiliary

Mrs. C. C. Long of Ozark, Arkansas, was named President Elect of the Woman's Auxiliary to the American Medical Association during the organization's convention in Atlantic City in June.

She will be installed as President at the 1968 convention in San Francisco, succeeding Mrs. Karl F. Ritter of Lima, Ohio.

Mrs. Long had served for two years as First Vice President of the Auxiliary and for three years as Chairman of the Rural Health Committee.

A native of Topeka, Kansas, Mrs. Long attended the University of Kansas. She and Doctor Long are the parents of four children.

Cigarettes: Most Common Pollutant

Although pulmonary emphysema has a greater morbidity rate than bronchogenic carcinoma, the principle exciting cause of these two conditions is identical. According to Burgess and Burgess the common etiological factor is the inhalation of polluted air, with cigaret smoke by far the most common pollutant.

Included in their documentation is a study of maximum expiratory flow on 222 male patients in the Seattle Veterans Administration Hospital. Heavy smokers show a greater MEF loss than light smokers, and those who smoke their cigarettes to the end also have a heavier MEF loss than those who leave longer butts.

The authors also refer to 47,866 Seventh Day Adventists in California. Although Seventh Day Adventists do not smoke, they are subject to the same degree of air pollution as are the other residents. There were 4 deaths from primary emphysema for the Seventh Day Adventists during the five-year study period and according to the current California rate for the same disease 22 were expected.

Conclude the authors: the usual cause of pulmonary damage that "... produces so many respiratory cripples, most of whom suffer for years and die before their time, is the habitual inhalaticn of cigarette smoke."

ACP Announces PG Courses For 1967-68

The American College of Physicians has announced a series of 21 postgraduate medical education courses it will conduct during 1967-68.

Tuition fees include $60 for each course for ACP members and $100 for nonmembers.

The complete schedule is as follows:

Sept. 18-21—"Hematology: Current Concepts and Developments," Los Angeles.

Oct. 2-6—"Clinical Cardiology," Loma Linda, California.

Oct. 9-13—"Renal Diseases and Fluid and Electrolyte Balance," Seattle.

Nov. 15-18—"Neurologic Aspects of Internal Medicine," Durham, North Carolina.

Nov. 27-30—"Medical Genetics," Ann Arbor, Michigan.

Dec. 4-8—"Radio-Isotopes and Nuclear Radiations in Medicine," Berkeley, California.

Dec. 11-15—"Advances in Medical Oncology," Houston, Texas.

Jan. 15-19—"Neurology and the Internist," Miami Beach.

Feb. 5-9—"Psychiatry and the Internist," Los Angeles.

Feb. 19-23—"Intensive Care Units," Cincinnati.

Feb. 28-Mar. 2—"Hypertensive Cardiovascular Diseases: Mechanisms and Treatment," Montreal.

Mar. 14-16—"The Clinical Selection of Patients for Cardiac Surgery," Rochester, Minnesota.

Mar. 18-22—"Psychiatry and the Internist," Albany, New York.

Mar. 27-30—"Current Concepts in Physiology of Respiration, Circulation and Electrolyte Metabolism," Boston.

Apr. 22-26—"Clinical Endocrinology — Recent Advances in Diagnosis and Treatment," Rochester, Minnesota.

May 12-15—"Frontiers in Gastroenterology," Philadelphia.

May 20-24—"The Prevention and Early Detection of Disease in Clinical Practice," Philadelphia.

May 27-31—"Auscultation of the Heart," Philadelphia.

June 10-14—"Basic Principles in Internal Medicine—1968," Iowa City, Iowa.

June 17-19—"Intensive Care Units," Denver.

June 19-21—"Infectious Diseases—Mechanisms and Manifestations," Baltimore.

Additional information may be obtained by contacting Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania.

Dr. Buff Named to Pollution Panel

Dr. I. E. Buff of Charleston recently was appointed by Gov. Hulett C. Smith to the West Virginia Air Pollution Control Commission.

Woman's Auxiliary To Hold 43rd Annual Session

The presidents of the Woman's Auxiliaries to the American Medical Association and the Southern Medical Association will be guest speakers at the 43rd Annual Meeting of the Woman's Auxiliary to the West Virginia State Medical Association this month.

Mrs. C. T. Wilkinson

Mrs. Karl F. Ritter

The meeting will be held concurrently with the 100th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 24-26.

Mrs. Hu C. Myers of Philippi, President of the State Auxiliary, said that Mrs. Karl F. Ritter of Lima, Ohio, and Mrs. Charles T. Wilkinson of Wake Forest, North Carolina, will address the sessions. Mrs. Ritter was recently installed as President of the Woman's Auxiliary to the American Medical Association, and Mrs. Wilkinson heads the Auxiliary to the Southern Medical Association.

Other guests of the Auxiliary will include Mrs. Chester Young, National AMA-ERF Chairman; Mrs. Frank Gastineau, a member of the Board of Directors of the American Medical Political Action Committee; and Mrs. William B. Walsh, wife of one of the honor guests of the State Medical Association.

Mrs. Myers will preside at the sessions, which are expected to attract more than 200 physicians' wives.

Pre-Convention Meetings

A pre-convention meeting of the Executive Board will be held at 4 P.M. on Wednesday, August 23, after the first session of the State Medical Association's House of Delegates.

Members of the Auxiliary are cordially invited to attend the House session, which will feature an address by Dr. Milford O. Rouse of Dallas, Texas, President of the American Medical Association.

Address by Doctor Walsh

Auxiliary members also are encouraged to attend the formal opening of the Association's Annual Meeting on Thursday morning, August 24, beginning at 9 A.M. The principal speaker will be Dr. William B. Walsh of Washington, Physician-in-charge of the Hospital Ship SS Hope.

Following Doctor Walsh's address, the Auxiliary will open its own convention in the Fillmore and Van Buren Rooms at The Greenbrier.

First Business Session

The Auxiliary's general business sessions will be held on Thursday and Friday mornings. Afternoons will be free for committee meetings, recreation, and other activities.

Mrs. Myers will preside at the formal opening Thursday morning, and Mrs. D. E. Greeneltch of Wheeling will give the pledge of loyalty.

The business of the first session will include recommendations of the Board, committee reports, introduction of honor guests and county presidents, report of the Nominating Committee and election of the 1968 Nominating Committee.

Keynote Address by Mrs. Ritter

Mrs. Ritter will deliver the keynote address at the first general business session.

Mrs. Ritter, wife of a general practitioner, has been active in Auxiliary work for 25 years. She has held the presidency of her county and state auxiliaries as well as that of the Auxiliary to the AMA.

She was chairman of the national AMA-ERF Committee for three years, and for the past six years has been a member of the National Board, serving four years as Finance Secretary, one as Treasurer and one as Director.

Indiana-born Mrs. Ritter received degrees from Otterbein College and Western Reserve University in Ohio, worked as a branch librarian and for many years did volunteer work as a hospital librarian. She and Doctor Ritter were college classmates and were married in 1931.

She has given generously of her time to a number of civic and cultural groups. In recognition of her many services and achievements, she was elected "Woman of the Year" in Lima in 1951, and scholarships to the Lima Campus of Ohio State University were awarded and named in her honor in 1964 and 1965.

Past Presidents Luncheon

Mrs. Wilson P. Smith of Huntington, Immediate Past President, will preside at a luncheon honoring Past Presidents of the Auxiliary at 12:30 on Thursday, August 24.

Members of the Auxiliary are cordially invited to attend a special Medicine and Religion Program at 2 P.M. that same day. The topic, "The Physician's Dilemma in the Changing Attitudes Toward Morals," will be discussed by Doctor Rouse; The Rev. Dr. Paul B. McCleave of Chicago, Director of the AMA's Department of Medicine and Religion; and The Most Rev. Joseph Brunini, Apostolic Administrator of the Catholic Diocese of Natchez-Jackson in Mississippi.

Anniversary Ball

An Anniversary Ball, arranged by the Woman's Auxiliary to the Raleigh County Medical Society, will

be held in Chesapeake Hall on Thursday evening, beginning at 9 P.M.

Second General Session

The Auxiliary's Second General Business Session will be held at 9:30 A.M. on Friday, August 25. An address by Mrs. Charles T. Wilkinson of Wake Forest, North Carolina, President of the Woman's Auxiliary to the Southern Medical Association, will be followed by the presentation of Mesdames Young, Gastineau and Walsh.

The election of new officers and Mrs. Myers' presidential address will follow additional committee reports and other business.

Mrs. Ritter will install Mrs. Rupert W. Powell of Fairmont as President and other new officers. Mrs. Powell's inaugural address will be preceded by the presentation of the President's Pin and Gavel by Mrs. Myers to Mrs. Powell, and the presentation of the Past President's Pin by Mrs. Smith to Mrs. Myers.

Friday Afternoon Entertainment

Friday afternoon has been left free of business. There will be a bridge party arranged by the Woman's Auxiliary to the McDowell County Medical Society, and a golf tournament arranged by the Woman's Auxiliary to the Logan County Medical Society. Members are invited to visit the Exhibit Center during this free period.

Cocktail Party-Banquet-Ball

A full evening of entertainment and festivities is in store for Friday night.

A cocktail party will begin at 6:30 P.M., and this will be followed by the Centennial Banquet, at which Dr. Perry E. Gresham, President of Bethany College, will serve as principal after-dinner speaker. The Centennial Ball will top off the evening.

Post-Convention Conference

The Auxiliary will conduct its post-convention conference and board meeting on Saturday morning, August 26, beginning at 10 A.M. Mrs. Powell will preside at the session in the Fillmore and Van Burean Rooms.

Second Session of House of Delegates

Members of the Auxiliary are cordially invited to attend the second and final session of the State Medical Association's House of Delegates on Saturday afternoon, beginning at 2:30 P.M.

Dr. Richard E. Flood of Weirton, President of the State Medical Association, will deliver his presidential address, and Dr. Richard V. Lynch, Jr., of Clarksburg, will be installed as his successor.

A cocktail party and reception honoring the officers of the West Virginia State Medical Association will be held on the Chesapeake Hall Terrace on Saturday evening, beginning at 6:30 P.M. All members of the Auxiliary, the State Medical Association, exhibitors and guests are invited to attend.

Convention Chairmen

Mrs. Pat A. Tuckwiller of Charleston and Mrs. C. R. Davisson of Weston are Chairman and Co-Chairman, respectively, for this year's Auxiliary convention.

Mrs. Hu C. Myers
President

Occupational Health Congress In Atlanta

The American Medical Association will sponsor its 27th Congress on Occupational Health in Atlanta, Georgia, September 25-26.

Dr. Milford O. Rouse of Dallas, Texas, President of the AMA, will head a list of several prominent speakers.

There will be no registration fee, and the program is acceptable for 11 elective hours by the American Academy of General Practice.

Other information may be obtained by writing to: Council on Occupational Health, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Fiske Fund Trustees Announce Dissertation Title

Trustees of the Fiske Fund of the Rhode Island Medical Society have announced the selection of "The Challenge of Obstetric Anesthesia" as the subject for the Prize Dissertation of 1967.

An award of $500 will be made for the best dissertation on the subject. The dissertations will be particularly graded on the basis of original work by the authors.

Entries must be submitted no later than December 11, 1967 and should not exceed 10,000 words.

Additional information may be obtained by writing to Dr. John E. Farrell, 106 Francis Street, Providence, Rhode Island 02903.

Four Generations of Beaumont Family Practiced Medicine in New Cumberland

Medicine is a profession in which young men tend to follow in their fathers' footsteps. But the practice of medicine has been a tradition for more than a century for the Beaumont family and has extended through four generations. A Doctor Beaumont has been the counselor and medical adviser at birth, through life, and during the final illnesses of thousands of individuals in the New Cumberland area of West Virginia. Here, in brief, is the history of Beaumont physicians.

Dr. William Beaumont

1804-1867

The first physician in this illustrious family was Dr. William Beaumont. He was born and educated in England, came to the United States as a young man and settled in Lisbon, Ohio, where he became engaged in the manufacture of woolens. He also was a minister of the Christian Church. After studying medicine with a Dr. George McCook, he applied himself to the art of healing, practicing in New Cumberland. He also acquired considerable knowledge of physics.

Dr. Godfrey L. Beaumont

1837-1891

Dr. Godfrey L. Beaumont, the son of Dr. William Beaumont, was born in Ohio, but was brought to New Cumberland with his family when he was a youth. He inherited a love for medicine and at the age of 18 began preparing himself for a professional career by studying under his father and attending the Eclectic Medical Institute in Cincinnati. He began his practice in 1869 but did not acquire his license until 1881, the first year licensure was required in West Virginia.

Dr. Frank P. Beaumont

1865-1930

Dr. Frank P. Beaumont attended Eclectic Medical College in Cincinnati and received the Doctor of Medicine Degree. He did postgraduate work in New York and went into practice with his father, Dr. Godfrey L. Beaumont, in New Cumberland in 1887. He was President of the West Virginia Eclectic Medical Association and was Hancock County Health Officer for 20 years.

Dr. Dudley H. Beaumont

1895-

Dr. Frank P. Beaumont had two sons who went into medical practice, one of whom is Dr. Dudley H. Beaumont, who is now practicing in Wellsville, Ohio. Dr. Dudley Beaumont is a graduate of Jefferson Medical College in Philadelphia and once practiced with his father. Once, while he was a medical student, a woman sent for him and explained that she wanted the distinction of having four generations of Beaumonts diagnose and prescribe for her.

Dr. Godfrey L. Beaumont

1909-1960

The second Dr. Godfrey Beaumont was a brother of Dr. Dudley Beaumont. He received his medical degree from the University of Pennsylvania and after internship, commenced medical practice in New Cumberland. An illness forced him out of private practice in 1948, and he entered the Public Health Service in Florida. After several years he resigned to re-enter private practice at Sebring, Florida, until his sudden death in 1960.

Dr. Charles L. Wilbar Heads State Medical Program

Dr. Charles L. Wilbar, Jr., has assumed duties as Director of the West Virginia Regional Medical Program for Heart Disease, Cancer and Stroke.

Announcement of the appointment, effective June 1, was made by Dr. Richard V. Lynch, Jr., of Clarksburg, Chairman of the Executive Committee of the Regional Advisory Group for the program, and Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine who had been serving as acting director.

Charles L. Wilbar, M. D.

At the same time, Dr. Harry B. Heflin, Acting President of WVU, announced Doctor Wilbar's appointment as Clinical Professor of Medicine in preventive medicine and public health.

A native of Philadelphia, Doctor Wilbar has been prominent in public health work for many years in both Pennsylvania and Hawaii. For 10 years prior to last January he was Secretary of Health in Pennsylvania.

The new director attended the University of Pennsylvania, where he earned his A.B. and M.D. degrees. He completed a residency in pediatrics at Mary Drexel Children's Hospital in Philadelphia and Children's Hospital in Cincinnati, and also served a residency in medicine at Queen's Hospital in Honolulu.

His academic appointments have included: lecturer in the School of Public Health Nursing, University of Hawaii; lecturer in the graduate School of Public Health, University of Pittsburgh; Visiting Professor of Public Health and Preventive Medicine, University of Pennsylvania; and Associate Professor, Department of Public Health Administration, Johns Hopkins University School of Hygiene and Public Health.

Doctor Wilbar has served as President of the Conference of State and Provincial Health Authorities of North America, President of the Association of State and Territorial Health Officers, and in 1966, he was named President Elect of the American College of Preventive Medicine. He is also a member of the governing council of the American Public Health Association, a member of the Board of Directors of the National Multiple Sclerosis Society, and has served as a member of the Board of Directors of the American National Council for Health Education of the Public, Inc.; Chairman of the Ohio River Valley Water Sanitation Commission; and Chairman of the Interstate Commission on the Potomac River Basin.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1967

Aug. 24-26—100th Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.

Sept. 7-9—Am. Assn. of Ob. and Gyn., Hot Springs, Va.
Sept. 8-9—Maryland Medical, Ocean City.

Sept. 9—PG Course in "Cardiac Auscultation Review," South Charleston.

Sept. 15-23—AAGP, Dallas.
Sept. 22-29—Col. of Am. Pathologists, Chicago.
Sept. 26-28—Ky. Medical, Louisville.
Sept. 27-30—Penn. Medical, Philadelphia.
Sept. 29-Oct. 1—W. Va. Heart Assn., Wheeling.
Sept. 29-Oct. 3—Am. Soc. of Anes., Las Vegas.

Oct. 2-6—ACS, Chicago.
Oct. 5—Rural Health Conf., Jackson's Mill.
Oct. 5-7—Assn. of Am. Phys. & Sur., Houston.
Oct. 12—Bluefield Sanitarium Seminar, Bluefield.
Oct. 19-21—Va. Medical, Alexandria.
Oct. 20-24—Am. Heart Assn., San Francisco.
Oct. 21-26—Am. Acad. of Ped., Washington.
Oct. 25-28—Cong. of Neurological Sur., San Francisco.
Oct. 29—Am. Assn. of Oph., Chicago.
Oct. 29-Nov. 3—Am. Acad. of Oph. and Otol., Chicago.

Nov. 13-16—Southern Medical, Miami Beach.
Nov. 16-19—Nat. Soc. for Crippled Children & Adults, Los Angeles.
Nov. 25-26—Am. Col. of Chest Phys., Houston, Texas.
Nov. 26-29—AMA Clinical Meeting, Houston, Texas.
Nov. 29-Dec. 3—Am. Med. Women's Assn., Atlanta.

Dec. 2-7—Am. Acad. of Dermatology, Chicago.
Dec. 4-6—Sou. Surgical Assn., Hot Springs, Va.

1968

Jan. 17-18—Am. Rheumatism Assn., Baltimore.
Jan. 20-25—Am. Acad. of Orthopaedic Surgeons, Chicago.
Jan. 29-31—Soc. of Thoracic Sur., New Orleans.

Feb. 3-7—Am. Acad. of Allergy, Boston.
Feb. 6-10—Am. Col. of Radiology, Chicago.
Feb. 28-March 3—Am. Col. of Cardiology, San Francisco.

March 18-20—Am. Acad. of Ped., Atlanta.
March 24-29—Am. Col. of Allergists, Denver.
March 29-31—Am. Soc. of Int. Med., Boston.

April 1-5—ACP, Boston.
April 16-19—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 17-19—Maryland Medical, Baltimore.
April 22-24—Am. Assn. for Thoracic Surg., Pittsburgh.
April 22-25—Am. Col. of Ob. & Gyn., Chicago.
April 25-26—Am. Hosp. Assn., Hollywood, Fla.

May 1-2—Am. Ped. Soc., Atlantic City.
May 7-8—Assn. of Am. Phys., Atlantic City.
May 12-17—Am. Psy. Assn., Boston.
May 13-16—Am. Urological Assn., Miami Beach.
May 14-17—Ohio Medical, Cincinnati.
May 19-22—Nat. TB Assn., Houston.
May 23-25—Am. Gyn. Soc., Hot Springs, Va.

June 15—Acad. of TB Phys., San Francisco.
June 15-16—Am. Diabetes Assn., San Francisco.
June 16-20—Am. Col. of Chest Phys., San Francisco.
June 16-20—Am. Col. of Preventive Med., San Francisco.
June 16-20—AMA, San Francisco.
June 20-22—Am. Med. Women's Assn., San Francisco.
June 26-27—Am. Geriatrics Soc., New Orleans.

THE WEST VIRGINIA STATE MEDICAL ASSOCIATION

Announces a

Postgraduate Course in

"CARDIAC AUSCULTATION REVIEW WITH CASE PRESENTATIONS"

In Cooperation With
Cabell-Huntington Hospital, Cabell-Wayne Heart Association and
The West Virginia Department of Health

at

Herbert J. Thomas Memorial Hospital
4605 MacCorkle Avenue, S. W.
South Charleston, W. Va.

Saturday, September 9, 1967

The purpose of this course is to review basics of the diagnosis of heart disease by ausculatory skills through use of taped and live examples by stethophonic transmission.

Course Outline: 9:30 A.M.-12 N.—Review of the Origin and Means of Heart Sounds and Murmurs with Taped Examples of Pathology.

12 N.-1:30 P.M.—Luncheon in the hospital cafeteria.

1:30-3:30 P.M.—Visiting internists and cardiologists will present no more than four cases of valvular heart disease and congenital heart disease.

Faculty: D. Sheffer Clark, M. D., Huntington; William S. Sheils, M. D., Huntington; and Robert J. Marshall, M. D., Morgantown. Several cardiologists and internists from the Charleston area will participate as discussants.

Registration Fee: $5.00 (includes lunch)
Maximum Registration: 60
AAGP Credit Applied For

For advanced registration, please complete the following form and mail to: West Virginia State Medical Association, P. O. Box 1031, Charleston, W. Va. 25324.
Checks should be made payable to "West Virginia State Medical Association."

Please register me in the Cardiac Auscultation Review course to be presented at Thomas Memorial Hospital in South Charleston on Sept. 9. My registration fee is (is not) enclosed.

Name (please print) _____ *Specialty* _____

Address _____ *City* _____

CONVENTION PROGRAM

100th Annual Meeting

of the

West Virginia State Medical Association

THE GREENBRIER, WHITE SULPHUR SPRINGS
August 24-26, 1967

WEDNESDAY MORNING
August 23
(Eastern Daylight Time)

9:00-5:00—Registration, Main Floor Lobby.

10:00—Pre-Convention Meeting of the Council. Seigle W. Parks, M. D., *presiding* (Lee Room, Virginia Wing).

WEDNESDAY AFTERNOON

1:30—Cancer Committee. Hu C. Myers, M. D., *presiding* (Buchanan Room).

3:00—First Session of the House of Delegates. Richard E. Flood, M. D., *presiding* (Chesapeake Hall).

Invocation—Tracy N. Spencer, M. D.

Address: Milford O. Rouse, M. D., President, American Medical Association.

Business Meeting.

THURSDAY MORNING
August 24

8:00—Motion Pictures. John J. Mahood, M. D., *in charge* (Governor's Hall).

"Non-Syphilitic Venereal Diseases" and "Management of Mass Casualties."

8:30-5:00—Registration, Main Floor Lobby.

Opening Exercises
(Governor's Hall)

9:00—Call to Order—Ray S. Greco, M. D., Chairman, Program Committee.

Invocation—The Rev. Dr. Paul B. McCleave, Director of the Department of Medicine and Religion of the American Medical Association.

Address of Welcome—Richard E. Flood, M. D., President, West Virginia State Medical Association.

Address: William B. Walsh, M. D., Washington, D. C., Founder, President and Medical Director of Project HOPE.

First General Session

Moderators: Ray S. Greco, M. D., and Joseph D. Romino, M. D.

9:45—Brian Blades, M. D., Lewis Saltz Professor of Surgery and Chairman, Department of Surgery, George Washington University School of Medicine, Washington, D. C. Subject: "The Management of Severe Trauma."

10:30—Recess for Visiting Exhibits.

11:00—John C. Ullery, M. D., Professor and Chairman, Department of Obstetrics and Gynecology, Ohio State University College of Medicine, Columbus. Subject: "Advances in the Use of Progestagens (The Pill)."

11:45—Recess for Lunch and Visiting Exhibits.

12:15—Luncheon Honoring Past Presidents of the West Virginia State Medical Association. Seigle W. Parks, M. D., *presiding* (Tyler Room).

THURSDAY AFTERNOON

2:00—Medicine and Religion Program (Governor's Hall). "The Physician's Dilemma in the World of Changing Attitudes Toward Morals."

Moderator: The Rev. Dr. Paul B. McCleave, Director, AMA Department of Medicine and Religion.

The Most Rev. Joseph B. Brunini, Apostolic Administrator, Catholic Diocese of Natchez-Jackson, Mississippi.

Milford O. Rouse, M. D., President, American Medical Association.

3:30—Open Meeting, West Virginia State Society of Allergy. Robert H. Mutch, M. D., *presiding* (Fillmore and Van Buren Rooms).
Moderator: Merle S. Scherr, M. D.

Guest Speakers: Howard G. Rapaport, M. D., New York City, President of the American College of Allergists. Subject: "Practical Allergy in General Medicine Today."

Bernard Berman, M. D., Brookline, Massachusetts. Subject: "Advances in Pediatric Allergy."

Philip Blank, M. D., Pittsburgh. Subject: "Urticaria, Migraine, Insect and Miscellaneous Allergies."

Irvin Caplin, M. D., Indianapolis, Indiana. Subject: "Bronchial Asthma and Its Management."

Joseph H. Fries, M. D., New Hyde Park, New York. Subject: "Management of Food Allergy."

Mayer A. Green, M. D., Pittsburgh. Subject: "Nasal Allergy and Its Management."

A. Harvey Neidorff, M. D., Altoona, Pennsylvania.—Subject: "Allergic Contact and Atopic Dermatitis."

3:30—Resolutions Committee. Maynard P. Pride, M. D., *presiding* (Tyler Room).

5:00—Committee on Nominations. Albert C. Esposito, M. D., *presiding* (Jackson Room).

THURSDAY EVENING

6:00—Cocktail Party, University of Virginia Alumni Fund, Medical Division, James P. Baker, M. D., *in charge.*

6:30—Cocktail Party, West Virginia Chapter, Medical College of Virginia Alumni Association. W. Alva Deardorff, M. D., *in charge* (West Virginia Room).

9:30—Anniversary Ball. Arranged by the Woman's Auxiliary to the Raleigh County Medical Society (Chesapeake Hall).

FRIDAY MORNING

August 25

8:00—Motion Pictures. John J. Mahood, M. D., *in charge* (Governor's Hall).

"Technical Procedures for Diagnosis and Therapy in Children" and "Dynamics of Tumor Embolism."

8:30-5:00—Registration, Main Floor Lobby.

Second General Session

Moderators: Richard W. Corbitt, M. D., and Robert Greco, M. D.

9:30—Charles A. Doan, M. D., Dean Emeritus, Ohio State University College of Medicine, Columbus. Subject: "Progress in the Control of the Leukemias and Lymphomata."

10:15—John K. Lattimer, M. D., Professor and Chairman of the Department of Urology, College of Physicians and Surgeons of Columbia University, and Director of the Squier Urological Clinic, New York City. Subject: "Prostatic Cancer: New Findings Through the Electron Microscope, Tissue Culture and Time Lapse Photography."

11:00—Recess for Visiting Exhibits.

11:30—Dana L. Farnsworth, M. D., Henry K. Oliver Professor of Hygiene and Director of University Health Services, Harvard University. Subject: "The Drug Problem Among Young People."

12:15—Recess for Lunch and Visiting Exhibits.

FRIDAY AFTERNOON

2:00—Section on Internal Medicine. George A. Curry, M. D., *presiding* (Governor's Hall).

Guest Speaker: Charles A. Doan, M. D., Columbus, Ohio. Subject: "Some New Therapeutic Advances of Significance to the Internist."

Business Meeting.

2:00—Joint Meeting of the Sections on Pediatrics and Urology. W. Gene Klingberg, M. D., and D. Franklin Milam, M. D., *presiding* (Fillmore and Van Buren Rooms).

Guest Speakers: John K. Lattimer, M. D., New York City. Subject: "Physiological Testing and the Problem of Reflux in Children."

Clark D. West, M. D., Professor of Pediatrics, University of Cincinnati College of Medicine. Subject: "Medical Therapy of Chronic Urinary Tract Infection in Children."

Separate Business Meetings.

2:00—West Virginia Radiological Society. W. Alva Deardorff, M. D., *presiding* (Pierce Room).

Guest Speaker: Andrew K. Poznanski, M. D., Director of the School of Radiologic Technology at Henry Ford Hospital, Detroit, Michigan. Subject: "Breast Radiography: Pathologic—Radiologic Correlation."

2:00—West Virginia Society of Anesthesiologists. Norman W. B. Craythorne, M. D., *presiding* (Washington Room, Virginia Wing).

Guest Speaker: Paul E. Huffington, M. D., Memorial Hospital, Easton, Maryland. Subject: "The Law and Doctor Jones."

2:00—Section on Neurology, Neurosurgery and Psychiatry. David M. Wayne, M. D., *presiding* (West Virginia Room).

Guest Speaker: Dana L. Farnsworth, M. D., Cambridge, Massachusetts. Subject: "Community Mental Health Centers—Progress and Problems."

2:00—Section on Surgery. Ray E. Burger, M. D., *presiding* (Director's Room).

Guest Speaker: Brian Blades, M. D. Washington, D. C. Subject: "The Surgical Treatment of Metastatic Lung Tumors."

2:00—Section on Orthopedic Surgery. Thomas F. Scott, M. D., *presiding* (Jackson Room).

Guest Speaker: Paul A. Kelley, M. D., Ann Arbor, Michigan. Subject: "The Surgical Treatment of Ankylosing Spondylitis."

2:00—West Virginia Obstetrical and Gynecological Society. Daniel A. Mairs, M. D., *presiding* (Mountaineer Room).

Guest Speaker: John C. Ullery, M. D., Columbus, Ohio. Subject: "The Management of Operative Urinary Tract Injuries."

3:00—West Virginia Chapter, American Society of Internal Medicine. Jack H. Baur, M. D., *presiding* (Governor's Hall).

Business Meeting.

4:00—West Virginia Academy of Ophthalmology and Otolaryngology. William C. Morgan, M. D., *presiding* (Lee Room, Virginia Wing).

Business Meeting.

FRIDAY EVENING

"Centennial Banquet and Ball"

(Chesapeake Hall)

6:30—Cocktails.

7:30—Banquet. Speaker: Dr. Perry E. Gresham, President of Bethany College.

9:00—Centennial Ball.

SATURDAY MORNING

August 26

8:00—Motion Pictures. John J. Mahood, M. D., *in charge* (Governor's Hall). "Chronic Bronchitis" and "Reprieve from Lethal Infection."

9:00-2:00—Registration, Main Floor Lobby.

VAN LIERE—UNIVERSITY DAY PROGRAM

"Medical Education—Past, Current and Future."

Moderator: Clark K. Sleeth, M. D.

10:00—Kenneth R. Crispell, M. D., Dean, The University of Virginia Medical School

Charles A. Doan, M. D., Dean Emeritus, Ohio State University School of Medicine

Kinloch Nelson, M. D., Dean, Medical College of Virginia

John Parks, M. D., Dean, The George Washington University School of Medicine

William A. Sodeman, M. D., Dean Emeritus, Jefferson Medical College of Philadelphia

William S. Stone, M. D., Dean, University of Maryland School of Medicine

11:30—Recess for Visiting Exhibits.

SATURDAY AFTERNOON

1:30—West Virginia Association of Pathologists. Peter Ladewig, M. D., *presiding* (Jackson Room).

Business Meeting.

2:30—Second and Final Session of the House of Delegates. Richard E. Flood, M. D., *presiding* (Chesapeake Hall).

Invocation—Carl B. Hall, M. D.

Presidential Address: Richard E. Flood, M. D., President, West Virginia State Medical Association.

Introduction of President of Woman's Auxiliary to the West Virginia State Medical Association.

Presentation of AMA-ERF check to Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine.

Introduction of Honor Guests.

Business Meeting.

Election of Officers.

Installation of Richard V. Lynch, Jr., M. D., of Clarksburg, as President of the West Virginia State Medical Association.

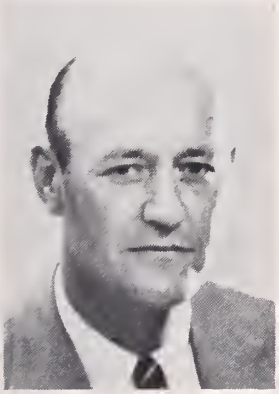
SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring Officers of the West Virginia State Medical Association (Chesapeake Hall Terrace).

CONVENTION SPEAKERS

(Biographical Sketches)

Dr. John K. Lattimer, Professor and Chairman of the Department of Urology at the Columbia University College of Physicians and Surgeons, is a native of Mount Clemens, Michigan.



John K. Lattimer, M. D.

He was graduated from Columbia College and received his M. D. degree in 1938 from the Columbia University College of Physicians and Surgeons.

He served an internship at Methodist - Episcopal Hospital in Brooklyn and served residencies in urology at Presbyterian Hospital, Babies Hospital and Vanderbilt Clinic in New York City.

He has been a member of the faculty at Columbia since 1940 and was named to his present position in 1955. From 1943 to 1946 he served with the Medical Corps of the U. S. Army and was stationed in England and Germany.

He is a Diplomate of the American Board of Urology and is currently serving as Chairman of the Committee for Pediatric Urology of the American Academy of Pediatrics. He also is a member of the American Medical Association, American College of Surgeons and American Urological Association.

Dr. William S. Stone, Dean of the University of Maryland School of Medicine, was born in Ogden, Utah.

William S. Stone, M. D.

Doctor Stone was graduated from the University of Idaho and received his M. D. degree in 1929 from the University of Louisville School of Medicine. He interned at William Beaumont General Hospital and served residencies at the Army Medical School and Fort McPherson Hospital. He was Chief of the Parasitic Disease Division at the Army Medical School, 1934-38.

From 1941 to 1943, Doctor Stone served as Chief of the Laboratories Division in the Surgeon General's Office. He served as a Consultant in Preventive Medicine and Chief of Research, North African and Mediterranean Theatres, 1943-45. He served as Commandant of the Army Medical Service Graduate School, 1950-54. He accepted appointment as Director of Medical Education and Research at the University of Maryland School of Medicine in 1954 and was named Dean the following year.

Doctor Stone is certified by the American Board of Pathology and the American Board of Preventive Medicine. He is a member of the Halstead Society and the District of Columbia Academy of Medicine.

Dr. John Parks, Dean of the George Washington University School of Medicine, was born in Muskogee, Oklahoma.

John Parks, M. D.

He was graduated from the University of Wisconsin and received his M. D. degree in 1934 from the University of Wisconsin School of Medicine. He interned at Cincinnati General Hospital, 1934-35, and served a residency in obstetrics and gynecology at Wisconsin General Hospital in Madison. He served one year as a member of the faculty at the University of Wisconsin School of Medicine.

From 1938 to 1944, Doctor Parks served as Chief Medical Officer in Obstetrics and Gynecology at the Gallinger Municipal Hospital in Washington, D. C. In 1944 he was named Professor of Obstetrics and Gynecology at George Washington. He was named Dean of the School of Medicine in 1947. He also served as Medical Director of the University Hospital from 1957 to 1965.

He is certified by the American Board of Obstetricians and Gynecologists and served as a Director from 1950-1961. He is a Past President of the American Association of Obstetricians and Gynecologists and served for seven years as a member of the Board of Governors of the American College of Surgeons. He is currently serving as President of the National Board of Medical Examiners and he is President Elect of the American Association of Medical Colleges.

The Rev. Dr. Paul B. McCleave, Director of the American Medical Association's Department of Medicine and Religion, was born in Joplin, Missouri.

Rev. Dr. Paul B. McCleave

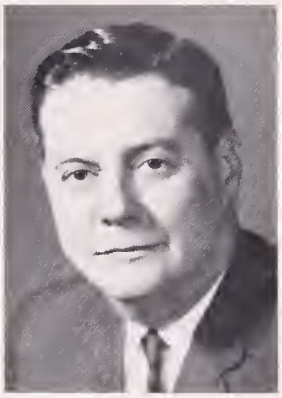
Doctor McCleave attended the College of Emporia in Kansas, the Presbyterian Theological Seminary in Omaha, Nebraska, and the University of Geneva in Switzerland.

In the 1940s and 1950s he served as a Presbyterian minister in Osawatomie and Concordia, Kansas, and in Bozeman, Montana. During World War II, he served as a Chaplain in the United States Navy for almost four years, retiring with the rank of Lieutenant Commander.

In 1947, he returned to his Alma Mater, the College of Emporia, serving there as President for five years.

He has held his present position as Director of the AMA Department of Medicine and Religion since 1961.

Dr. William B. Walsh of Washington, D. C., Founder, President and Medical Director of Project HOPE, is a native of Brooklyn, New York.


William B. Walsh, M. D.

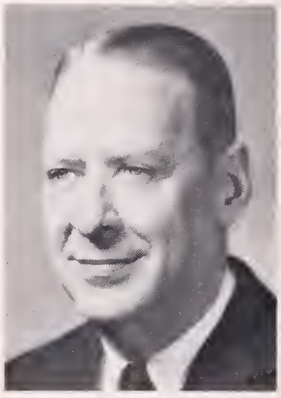
Doctor Walsh is a graduate of St. John's University and received his M. D. degree in 1943 from the Georgetown University School of Medicine. During World War II, he served as a medical officer aboard a destroyer in the South Pacific.

He was Assistant Professor of Internal Medicine at Georgetown in 1958 when President Dwight D. Eisenhower asked him to co-chair the Committee on Medicine and the Health Professions of the President's new People-to-People program.

At Doctor Walsh's suggestion, a Navy hospital ship was taken out of mothballs and was set afloat as the S. S. HOPE. Doctor Walsh later founded the People-to-People Health Foundation, Inc., the parent organization of Project HOPE, which sponsors the world-wide voyages of the S. S. HOPE.

Doctor Walsh is the recipient of many honors and is the author of two books about the voyages of the S. S. HOPE.

Dr. Dana L. Farnsworth, Henry K. Oliver Professor of Hygiene and Director of the University Health Service at Harvard University, was born in Troy in Gilmer County, West Virginia.


Dana L. Farnsworth, M. D.

He attended Glenville College and was graduated from West Virginia University. After serving as a high school teacher for two years in West Virginia, Doctor Farnsworth entered medical school and in 1933 received his M. D. degree from Harvard Medical College.

During World War II, Doctor Farnsworth served for five years in the Medical Corps of the United States Navy and was discharged with the rank of Commander. Before his appointment to his present position at Harvard in 1954, Doctor Farnsworth had served as Director of Health at Williams College and Medical Director and Acting Dean of Students at Massachusetts Institute of Technology.

Doctor Farnsworth is a Diplomate of the American Board of Psychiatry and Neurology and a Fellow of the American Psychiatric Association. He currently is serving as Chairman of AMA's Committee on Mental Health.

He has received honorary degrees from six colleges and universities and is the author or co-author of six books.

Dr. A. Harvey Neidorff, Chief of Allergy and Dermatology at Mercy Hospital in Altoona, Pennsylvania, is a native of New York City and was graduated from the City College of New York.

A. Harvey Neidorff, M. D.

He received his M. D. degree in 1937 from the University of Vienna and also had three years of postgraduate work in dermatology and allergy in that city.

He is a Fellow of the American College of Allergists and the American Academy of Allergy, an associate member of the American Academy of Dermatology and a member of the Society of Investigative Dermatology.

Doctor Neidorff was awarded the "Clemons Von Pirquet Gold Medal" in 1963 for his work in the field of allergy.

Dr. Kenneth R. Crispell, Dean of the University of Virginia School of Medicine, was born in Ithaca, New York.

Kenneth R. Crispell, M. D.

He received his M. D. degree in 1943 from the University of Michigan School of Medicine and he interned at Robert Packer Hospital in Sayre, Pennsylvania. He served residencies in internal medicine at the Robert Packer Hospital and at the Ochsner Clinic in New Orleans. He served in the Medical Corps of the United States Army, 1944-46, and was in private practice in Ithaca for one year.

Doctor Crispell joined the faculty of the University of Virginia School of Medicine in 1949 and was Associate Professor of Medicine when he resigned to accept appointment as Professor and Chairman of the Department of Medicine at New York Medical College. He returned to the University of Virginia in 1960 as Professor of Medicine and in 1962 was named Acting Dean. He was appointed Dean in 1964.

He is a Past President of the American Society for Clinical Research and he is a Fellow of the American College of Physicians. He is a member of the Medical Society of Virginia and the American Medical Association.

Dr. Philip Blank, Clinical Assistant Professor of Medicine, University of Pittsburgh School of Medicine, and Director of Allergy at the Brentwood Medical Group in that city, was graduated from the University of Pittsburgh in 1931. He received his M. D. degree in 1936 from the Georgetown University School of Medicine.

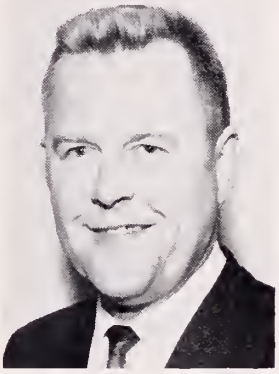
Philip Blank, M. D.

Doctor Blank also serves as Consultant Allergist at the Veterans Administration Hospital in Pittsburgh.

He is a Fellow of the American Academy of Allergy, American College of Allergists and the International Society of Allergology. He also is a member of the American Medical Writers Association and a Past President of the Pittsburgh Allergy Society.

He served with the Medical Corps of the United States Army during World War II, being released with the rank of Lieutenant Colonel.

Dr. Blair J. Henningsgaard of Astoria, Oregon, Chairman of the Board of Directors of the American Medical Political Action Committee, was born in Watertown, South Dakota.



Blair J. Henningsgaard, M. D.

Doctor Henningsgaard received his M. D. degree in 1943 from the University of Minnesota School of Medicine. He interned and served a residency at Good Samaritan Hospital in Portland, Oregon and his specialty is internal medicine. He served as a Captain in the Medical Corps of the United States Army, 1944-46.

Doctor Henningsgaard served for four years as Speaker of the House of Delegates of the Oregon Medical Association and was President of the organization, 1961-62. He has been a member of the House of Delegates of the American Medical Association since 1963 and has served on several occasions as a member of reference committees of the House.

Dr. John C. Ullery, Professor and Chairman of the Department of Obstetrics and Gynecology at the Ohio State University College of Medicine, is a native of Bradford, Ohio.

John C. Ullery, M. D.

He was graduated from Ohio State University and received his M. D. degree in 1932 from Jefferson Medical College of Philadelphia. He served an internship at the Pennsylvania Hospital and was a Fellow in Urology at Miami Valley Hospital in Dayton, Ohio. He also served a residency at the Philadelphia Lying-in Hospital.

He served as a member of the faculty at Jefferson Medical College and the Graduate School of the University of Pennsylvania and was Chief of Service of the Department of Obstetrics and Gynecology at Philadelphia General Hospital from 1936 until 1954 when he was named to his present position at Ohio State.

He is a Diplomate of the American Board of Obstetrics and Gynecology and is a Fellow of the American College of Surgeons and the American College of Obstetrics and Gynecology. He serves on the editorial board of several national medical journals and is the author of three textbooks and a large number of scientific papers which have appeared in medical journals.

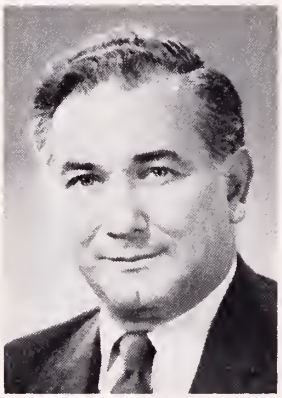
Dr. Mayer A. Green is serving as Clinical Assistant Professor of Medicine, University of Pittsburgh School of Medicine, and Senior Physician and Chief of the Allergy Departments at Columbia and Montefiore Hospitals in Pittsburgh.

Mayer A. Green, M. D.

Doctor Green was graduated from the University of Pittsburgh and received his M. D. degree in 1932 from the University of Pittsburgh School of Medicine. He interned and served a residency at the Montefiore Hospital in Pittsburgh and had additional training in allergy at Mt. Sinai and Roosevelt hospitals in New York City.

He is certified by the American Board of Internal Medicine and is a Fellow of the American College of Physicians. He is a Fellow and Past President of the American College of Allergists and a Fellow of the American Academy of Allergy, Academy of Psychosomatic Medicine and the American College of Chest Physicians. He is a member of the editorial boards of *Annals of Allergy* and *Review of Allergy*.

Dr. Howard G. Rapaport, Associate Clinical Professor of Pediatrics at the Albert Einstein College of Medicine in New York City, is a native of that city.



Howard G. Rapaport, M. D.

Doctor Rapaport received his M. D. degree in 1934 from the University of Bern School of Medicine in Switzerland and he interned and served residencies in New York City. He was certified by the American Board of Pediatrics in 1940.

He is Chief of the Children's Allergy Department at Abraham Jacobi Hospital in Bronx, New York, and he has practiced his specialty of allergy since 1938.

Doctor Rapaport is currently serving as President of the American College of Allergists and is a Past President of the Association of Convalescent Homes and Hospitals for Asthmatic Children. He is Assistant Secretary of the Allergy Section of the American Medical Association and serves as Associate Editor of *Journal of Asthma Research* and *Annals of Allergy*.

He is a member of the American Academy of Allergy, the American Academy of Pediatrics and the International Association of Allergology.

The Most Rev. Joseph B. Brunini, Apostolic Administrator of the Catholic Diocese of Natchez-Jackson, was born in Vicksburg, Mississippi.

Bishop Joseph B. Brunini

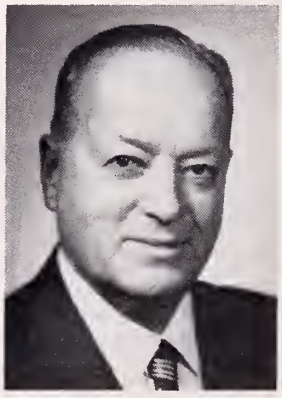
Bishop Brunini received his A. B. degree in 1930 from Georgetown University in Washington and the degree of Bachelor of Sacred Theology from the North American College in Rome before being ordained as a priest in 1933.

He studied later at Catholic University in Washington, where he received the degree of Doctor of Canon Law. He then returned to the Diocese of Natchez-Jackson, first as a parish priest. In 1941, he was appointed Chancellor of the Diocese. He held many diocesan assignments until his consecration as Auxiliary Bishop of the Diocese in 1957. Last year, Pope Paul VI appointed him to his present post.

Bishop Brunini is a Past President of the Catholic Hospital Association of the United States and has served as a Trustee of the American Hospital Association. He has served on the Blue Cross-Blue Shield Board in Mississippi for 20 years and is a member of the American Medical Association's Committee on Medicine and Religion.

At the present, he is also a member of the United States Bishops' Commission for Ecumenical Affairs and is Chairman of the special committee for dialogue with the Methodist Church.

Dr. Joseph H. Fries, Clinical Associate Professor of Pediatrics, New York Downstate Medical College, was born in Brooklyn, New York.

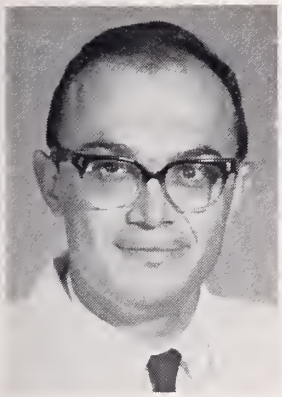


Joseph H. Fries, M. D.

He was graduated from Columbia College and received his M. D. degree in 1929 from the Columbia University College of Physicians and Surgeons. He interned at Bellevue Hospital, Kingston Avenue Hospital and Brooklyn Jewish Hospital. He served a residency at Kings County Hospital and also had postgraduate training at several medical centers abroad.

He is certified by the American Board of Pediatrics and is a Fellow of the American College of Physicians, American College of Allergists, American Academy of Pediatrics and the American Society of Clinical Nutrition. He is a Past President of the New York Allergy Society.

Dr. Andrew K. Poznanski, Director of the School of Radiologic Technology at Henry Ford Hospital in Detroit, Michigan, was born in Czestochowa, Poland.



Andrew K. Poznanski, M. D.

Doctor Poznanski received his M. D. degree in 1956 from McGill University in Montreal and he interned at Montreal General Hospital. He served a residency in radiology at Henry Ford Hospital in Detroit and is now a member of the staff at that hospital.

He is a Diplomate of the American Board of Radiology and is certified in Diagnostic Radiology by the Royal College of Physicians and Surgeons.

Doctor Poznanski is a member of the American Medical Association, the American College of Radiology, the Radiological Society of North America, the American Roentgen Ray Society, and the Society for Pediatric Radiology.

Dr. Clark D. West, Professor of Pediatrics at the University of Cincinnati College of Medicine, was born in Jamestown, New York.

Clark D. West, M. D.

Doctor West was graduated from the College of Wooster in Ohio and received his M. D. degree in 1943 from the University of Michigan School of Medicine. He interned and served a residency at University Hospital in Ann Arbor, Michigan, 1943-46. He served with the Medical Corps of the United States Army, 1946-47, and from 1948 to 1951 he served as a Fellow in Pediatrics at hospitals in New York City and Cincinnati.

He served as Assistant and Associate Professor of Pediatrics at the University of Cincinnati College of Medicine from 1951-1962, at which time he was appointed Professor. He also serves as Associate Director of the Children's Hospital Research Foundation in Cincinnati and is Attending Pediatrician at Children's Hospital and Cincinnati General Hospital.

He is a Past President of the Society for Pediatric Research and is a member of the American Pediatric Society and the American Society of Immunologists. He is a member of the Editorial Board of *The Journal of Pediatrics.*

Dr. Kinloch Nelson, Dean of the Medical College of Virginia, is a native of Richmond, Virginia.

Kinloch Nelson, M. D.

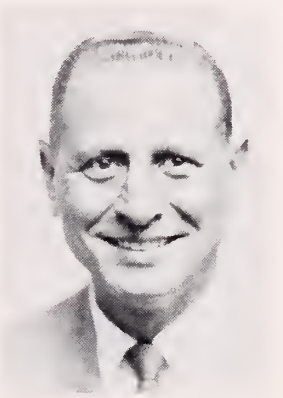
He was graduated from the University of Virginia and received his M. D. degree in 1937 from the University of Virginia School of Medicine. He served his internship and had residency training at the University of Minnesota Hospital and at Billings Memorial Hospital at the University of Chicago.

He practiced in Richmond from 1929-1942 and also was a member of the faculty of the Medical College of Virginia during that time. During World War II he served as a Major in the Medical Corps of the United States Army.

He served as Director of the Continuation Education program at MCV from 1949 to 1965. In 1958 he was appointed Professor of Medicine. He was named Associate Dean in 1962 and has served as Dean since 1963.

He is certified by the American Board of Internal Medicine and is a Fellow of the American College of Physicians. He is a Past President of the Richmond Academy of Medicine and served for three years as speaker of the House of Delegates of the Medical Society of Virginia.

Dr. Irvin Caplin is Assistant Professor of Pediatrics, Indiana University School of Medicine, and Director of the Allergy Clinic at Riley Hospital and Methodist Hospital Graduate Medical Center in Indianapolis.

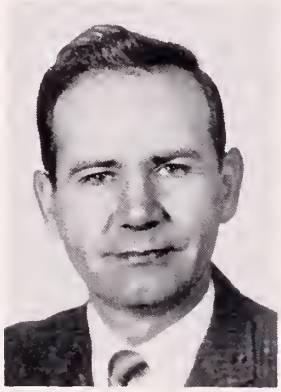


Irvin Caplin, M. D.

Doctor Caplin was graduated from Indiana University and received his M. D. degree in 1939 from the Indiana University School of Medicine. He interned at Lucas County Hospital in Toledo, Ohio, 1939-40, and served a residency in allergy and internal medicine at the University of Pittsburgh.

He is a Fellow of the American Academy of Allergy and the American College of Allergists and an associate member of the American College of Chest Physicians. He is the author of a book entitled *The Allergic Asthmatic* which will be published this year and is intended as a manual for patients.

Dr. Bernard A. Berman, Clinical Instructor in Pediatrics and Medicine, Tufts University School of Medicine, is a native of Boston, Massachusetts.


Bernard A. Berman, M. D.

Doctor Berman was graduated from Tufts College and received his M. D. degree in 1948 from the Tufts University School of Medicine. He interned at Jewish Hospital in Brooklyn, New York, and served residencies at that hospital and Children's Hospital in Boston.

He is certified by the American Academy of Pediatrics and is a Fellow of the American Academy of Pediatrics, American College of Allergy, American Academy of Allergy and the American College of Chest Physicians.

Doctor Berman currently is a Consultant in Pediatrics to the Chelsea Naval Hospital and serves as Assistant in Pediatrics at the Boston University School of Medicine.

Dr. Perry E. Gresham, President of Bethany College, is a native of Covina, California.

He received A. B. and B. D. degrees from Texas Christian University and completed requirements for the Ph.D. degree at the University of Chicago and Columbia University. He holds honorary degrees conferred on him by Texas Christian, Culver-Stockton College, University of Cincinnati, Youngstown University, Transylvania College and Chapman College.

Dr. Perry E. Gresham

He formerly served as Professor of Philosophy at Texas Christian University and is a past president of the Highland Broadcasting Company in Radford, Virginia. He has presented lectures at universities throughout this country, Canada, Mexico and the United Kingdom.

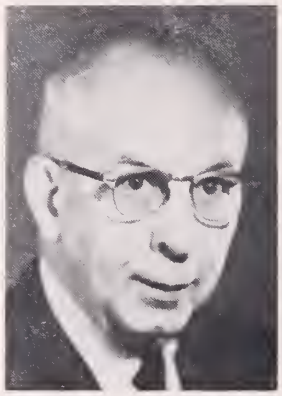
He is a past chairman of the Commission on Colleges and Universities, North Central Association, and a past president of the International Convention of Christian Churches (Disciples of Christ).

In 1963 he was one of five recipients of plaques from the Freedoms Foundation Leadership for Public Service in Education.

He is the author of four books.

Dr. Milford O. Rouse, President of the American Medical Association, was born in Jacksonville, Texas.

Doctor Rouse was installed as President of the AMA during the Annual Convention in Atlantic City in June. He served for three years as Speaker of the House of Delegates and, prior to that, had been Vice Speaker of the House for four years. He was named President Elect during the AMA meeting in Chicago last June.


Milford O. Rouse, M. D.

His parents were Southern Baptist missionaries and he spent part of his boyhood in Brazil. He was graduated from Baylor University and received his M. D. degree in 1927 from Baylor University College of Medicine. He interned at Fort Sam Houston Station Hospital, 1927-28.

Doctor Rouse has practiced in Dallas since 1928, specializing in gastroenterology. Since 1943, Doctor Rouse has been Clinical Professor of Medicine at the University of Texas Southwestern Medical School and he previously taught at the Baylor University College of Medicine when that school was located in Dallas.

Doctor Rouse has contributed more than a score of papers to journals throughout the country. He is a Past President of the Dallas Southern Clinical Society, the Texas Medical Association and the Southern Medical Association. He is a Diplomate of the American Board of Internal Medicine and a Fellow of the American College of Physicians.

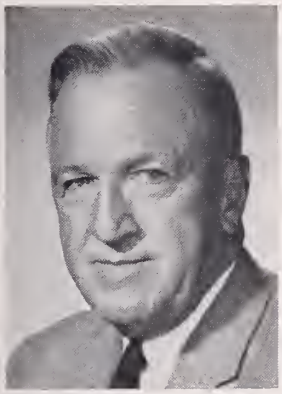
Dr. Paul E. Huffington, a member of the staff of Memorial Hospital in Easton, Maryland, is a former Instructor in Anesthesiology at the West Virginia University School of Medicine.

Paul E. Huffington, M. D.

Doctor Huffington attended Baltimore City College and Duke University and received his M. D. degree from the University of Maryland. He interned at St. Luke's Hospital in Denver and served residencies at Parkland Memorial Hospital in Dallas, Texas, and at the West Virginia University Medical Center.

His professional memberships include the American Society of Anesthesiologists and the American Medical Association.

Dr. Charles A. Doan, Dean Emeritus of the Ohio State University College of Medicine, was born in Nelsonville, Ohio.



Charles A. Doan, M. D.

He received his M. D. degree in 1923 from Johns Hopkins University School of Medicine. He was associated with the Rockefeller Institute of Research and the Thorndike Memorial Laboratory in Boston, 1924-30.

He served as Professor of Medicine and Director of the Department of Medical and Surgical Research at the Ohio State University College of Medicine, 1930-36.

He was Chairman of the Department of Medicine and Physician-in-Chief at the Starling-Loving University Hospital and St. Francis Hospital, 1936-44. In 1944, he was named Dean and Professor of Medicine of the Ohio State University College of Medicine.

Doctor Doan received the Distinguished Service Award of the American Medical Association in 1960 and is a past president of the American Society of Hematology.

He is certified by the American Board of Internal Medicine and is a member of the American College of Physicians. He served as Chairman of the Board of Governors of the ACP, 1951-54, and he is a member of the Columbus Academy of Medicine, Ohio State Medical Association and the American Medical Association.

Dr. Brian Blades, Lewis Saltz Professor of Surgery and Chairman, Department of Surgery, the George Washington University School of Medicine, also serves as Chief of Surgery at the George Washington University Hospital.

Brian Blades, M. D.

A native of Scottsville, Kansas, Doctor Blades was graduated from the University of Kansas and received his M. D. degree in 1932 from the Washington University School of Medicine in St. Louis. He interned at Henry Ford Hospital in Detroit, and served a residency in surgery at Bellevue Hospital (Cornell Division) in New York City, 1933-36. He also served as a Fellow in Thoracic Surgery at Washington University School of Medicine in 1936. He served as a member of the faculty at his alma mater from 1937-42.

During World War II, he served as Chief of Thoracic Surgery at Walter Reed General Hospital in Washington, D. C., and as a Consultant in Surgery to the Surgeon General, USA. He was awarded the Legion of Merit and was discharged in 1946 with the rank of Colonel.

Doctor Blades is certified by the American Board of Surgery and the American Board of Thoracic Surgery, and he is a member of several surgical societies including the American College of Surgeons.

He is Editor of *The Journal of Thoracic and Cardiovascular Surgery* and he serves on the Editorial Boards of *The American Surgeon, Annals of Surgery and Postgraduate Medicine.*

Dr. William A. Sodeman, Emeritus Dean and Emeritus Professor of Medicine at the Jefferson Medical College of Philadelphia, is a native of Charleroi, Pennsylvania.

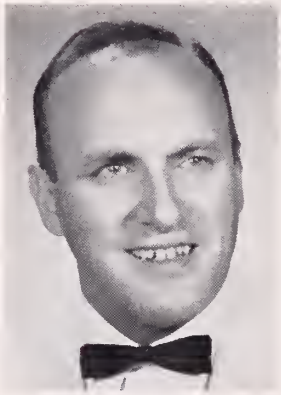
William A. Sodeman, M. D.

He received his M. D. degree in 1931 from the University of Michigan School of Medicine and served his internship at St. Vincent's Hospital in Toledo, Ohio, 1931-32. From 1932-1940 he served as Instructor in Medicine at Tulane University School of Medicine. He then was named Assistant Professor of Medicine and in 1941 he was appointed Professor and Head of the Department of Preventive Medicine. In 1946 he was named Professor of Tropical Medicine and Chairman of the Department of Tropical Medicine and Public Health.

He was appointed Professor and Chairman of the Department of Medicine at the Missouri University School of Medicine in 1953. He served in this position until 1957 at which time he accepted appointment as Magee Professor of Medicine and Head of the Department at Jefferson. He retired last month as Dean and Vice President of Medical Affairs at Jefferson. He is now serving as Scientific Director of the Life Insurance Medical Research Fund.

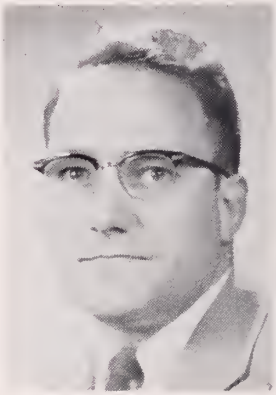
Doctor Sodeman is a Fellow of the American College of Physicians and has served as Treasurer of the national organization since 1963. He currently is serving as a member of the Council on Medical Education of the American Medical Association and was a member of a four-man team sent to South Vietnam in 1966 under the auspices of the AMA to study that country's health programs.

1967 PROGRAM COMMITTEE

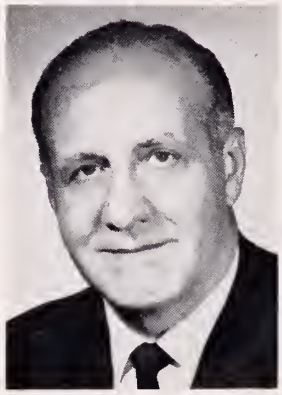


Ray S. Greco, M. D.
Weirton
Chairman

Richard W. Corbitt, M. D.
Parkersburg



Robert Greco, M. D.
Morgantown



Joseph D. Romino, M. D.
Fairmont

DELEGATES AND ALTERNATES

B-R-T (3)—Delegates, Charles L. Leonard, Elkins; Homer D. Martin, Dailey; and A. Kyle Bush, Philippi. Alternates, Raymond W. Cronlund, Philippi; E. E. Hutton, Jr., Elkins; and Karl J. Myers, Philippi.

BOONE (2)—Delegates, Harold H. Howell, Madison; and W. V. Wilkerson, Whitesville. Alternate, David E. Wallace, Madison.

BROOKE (1)—Delegate, W. T. Booher, Wellsburg. Alternate, J. P. McMullen, Wellsburg.

CABELL (9)—Delegates, C. A. Hoffman, Frank M. Peck, William L. Neal, Thomas F. Scott, Joseph E. Ricketts, Roy A. Edwards, Jr., David A. Haught, Joseph M. Farrell and Harold N. Kagan, Huntington. Alternates, Jack Leckie, Wilson P. Smith, Gilbert A. Ratcliff, I. Ewen Taylor, Richard J. Stevens, Ray Russell Hagley, John M. Bobbitt and C. Stafford Clay, Huntington.

CENTRAL WEST VIRGINIA (3)—Delegates, Cornelia B. Wilbur and Charles T. Lively, Weston; and John E. Echols, Richwood. Alternates, Rigoberto Ramirez, Buckhannon; C. R. Davisson, Weston; and R. L. Chamberlain, Buckhannon.

EASTERN PANHANDLE (3)—Delegates, Halvard Wanger, Shepherdstown; and L. Walter Fix and Leo H. T. Bernstein, Martinsburg. Alternates, S. Elizabeth McFetridge, Shepherdstown; and Daniel E. Hendricks and N. B. Groves, Martinsburg.

FAYETTE (2)—Delegates, Joe N. Jarrett, Oak Hill; and T. Kerr Laird, Montgomery. Alternates, W. B. Davis, Rainelle; and W. P. Bittinger, Oak Hill.

GREENBRIER VALLEY (2)—Delegates, Luther E. Rexrode, Marlinton; and Arnold J. Brody, White Sulphur Springs. Alternate, Stuart T. Bray, White Sulphur Springs.

HANCOCK (2)—Delegates, Dominic A. Brancazio and Ray S. Greco, Weirton. Alternates, David H. Williams and Myer Bogarad, Weirton.

HARRISON (4)—Delegates, Hugh M. Brown, Clarksburg; Robert D. Hess, Bridgeport; Boylston D. Smith and A. Robert Marks, Clarksburg. Alternates, Andrew J. Weaver, Clarksburg; Ray A. Harron, Bridgeport; Mehmet V. Kalaycioglu, Shinnston; and Herman Fischer, Clarksburg.

KANAWHA (15)—Delegates, Duke A. Dent, Andrew W. Goodwin, II, and Carl B. Hall, Charleston; E. Q. Hull, South Charleston; Page H. Seekford, Pat A. Tuckwiller, and W. Alva Deardorff, Charleston; Joseph A. Smith, Dunbar; A. Thomas McCoy and John Hartman, Charleston; Ralph J. Holloway, South Charleston; Milton J. Lilly, G. A. Shawkey and Carl J. Roncaglione, Charleston; and Donald E. Cunningham, St. Albans. Alternates, D. Brown Barber, Robert C. Bock, Carrel M. Caudill, Donald R. Gilbert, Miroslav Kovacevich, J. Dennis Kugel, William E. Lawton, R. Thomas Linger and L. B. Matthews, Charleston; Paul C. Soulsby, St. Albans; and Charles E. Staats, Henry M. Hills, Frederick Cooley, Marshall J. Carper and Robert E. Stone, Charleston.

LOGAN (2)—Delegates, Curtis L. V. Adams, Man; and Ray M. Kessel, Logan. Alternates, Thomas P. Long and Harold Van Hoose, Man.

MARION (3)—Delegates, Rupert W. Powell, William T. Lawson and Joseph T. Mallamo, Fairmont. Alternates, Robert R. Frye, Mannington; and Jack Calvin Morgan and Robert B. Hamilton, Fairmont.

MARSHALL (2)—Delegates, William Paul Bradford, Moundsville; and Andrew J. Barger, Glen Dale. Alternates, Serafin T. Ortiz, McMechen; and David L. Ealy, Moundsville.

MASON (1)—Delegate, Dan Glassman, Pt. Pleasant. Alternate, C. Leonard Brown, Pt. Pleasant.

McDOWELL (2)—Delegates, Stephen Mamick and Joseph C. Ray, Welch. Alternates, A. J. Villani and Ray E. Burger, Welch.

MERCER (4)—Delegates, John J. Mahood, Upshur Higginbotham, W. Hampton St. Clair, Jr., and Charles M. Scott, Bluefield. Alternates, David F. Bell, Jr., Bluefield; Joe E. McCary, Princeton; and W. E. Copenhaver, Bluefield.

MINGO (2)—Delegates, Robert J. Tchou and L. Lake Swigart, Williamson. Alternates, Russell A. Salton and Arthur E. Levy, Williamson.

MONONGALIA (5)—Delegates, Charles E. Andrews, George A. Curry, Robert Greco, W. E. King and Clark K. Sleeth, Morgantown. Alternates, Robert J. Fleming, Lawrence S. Miller, Ralph W. Ryan and Benjamin M. Stout, Jr., Morgantown.

OHIO (7)—Delegates, A. S. Daniel, Nime K. Joseph, E. Lee Jones, Camilla K. Bauer, Raymond J. Duffy, Stephen D. Ward and Robert T. Brandfass, Wheeling.

PARKERSBURG ACADEMY (5)—Delegates, S. William Goff and Charles W. Thacker, Parkersburg; Jack J. Stark, Belpre, Ohio; and Edward Shupala and Robert D. Crooks, Parkersburg. Alternates, Richard Hamilton, St. Marys; Lyle D. Vincent and Donald R. Lantz, Parkersburg; Asel P. Hatfield, Harrisville; and Charles H. Barnett, Parkersburg.

POTOMAC VALLEY (3)—Delegates, Vernon L. Dyer, Petersburg; Robert W. Bess, Jr., Piedmont; and Carl A. Liebig, Keyser. Alternates, Charles J. Sites, Franklin; Harry F. Coffman, Keyser; and Herbert P. Stelling, Romney.

PRESTON (2)—Delegates, W. Parke Johnson, Jr., Masontown; and William H. Harriman, Jr., Terra Alta. Alternates, Donald P. Brown and James V. Gainer, Jr., Kingwood.

RALEIGH (4)—Delegates, Forest A. Cornwell, Warren D. Elliott, Charles W. Merritt and Harry F. Cooper, Beckley. Alternates, Worthy W. McKinney, George A. Miller, B. B. Richmond and Richard G. Starr, Beckley.

SUMMERS (1)—Delegate, Buford W. McNeer, Hinton. Alternate, A. W. Holmes, Hinton.

WETZEL (2)—Delegates, Allen M. Dyer, Jr., Pine Grove; and Terrell Coffield, New Martinsville. Alternates, Kent M. Hornbrook and Lemoyne Coffield, New Martinsville.

TAYLOR (1)—Delegate, Gene W. Harlow, Grafton. Alternate, Wallace B. Murphy, Grafton.

WYOMING (1)—Delegate, Frank J. Zsoldos, Mullens. Alternate, Ross E. Newman, Mullens.

RECEPTION COMMITTEE

James S. Klumpp, *Chairman*

C. A. Hoffman
Frank J. Holroyd
Thomas G. Reed
D. E. Greeneltch

Edmund B. Flink
A. B. Curry Ellison
E. L. Crumpacker
D. Franklin Milam

Seigle W. Parks
Kenneth G. MacDonald
A. C. Chandler
Hu C. Myers

Harold N. Kagan
Michel A. Glucksman
E. J. Van Liere
Ray S. Greco

J. P. McMullen
Myer Bogarad
E. Lyle Gage
Albert C. Esposito

Thomas S. Knapp
David M. Wayne
James P. Baker
Joseph A. Smith

L. J. Pace
Tracy N. Spencer, Jr.
Buford W. McNeer
Thomas L. Harris

William L. Cooke
W. Alva Deardorff
William L. Claiborne
Clark K. Sleeth

Ray E. Burger
Bernard Zimmermann
William E. Gilmore
Daniel A. Mairs

George F. Evans
Richard W. Corbitt
Maynard P. Pride
J. C. Huffman

Official Program

WOMAN'S AUXILIARY

to the

West Virginia State Medical Association
43rd Annual Meeting

The Greenbrier
White Sulphur Springs
August 24-26, 1967

WEDNESDAY

August 23

3:00—First Session of the House of Delegates, State Medical Association (Chesapeake Hall).

Address: Milford O. Rouse, M. D., President, American Medical Association.

(Auxiliary Members are Invited and Urged to Attend).

4:00—Pre-Convention Board Meeting. Mrs. Hu C. Myers, President, *presiding* (Tyler Room).

THURSDAY MORNING

August 24

9:00—Formal Opening of the 100th Annual Meeting of the West Virginia State Medical Association (Governor's Hall).

Address by Dr. William B. Walsh, Physician-In-Charge of Ship SS HOPE, Washington, D. C.

(Auxiliary Members are Invited and Urged to Attend).

9:45—Formal Opening of the Convention, Mrs. Hu C. Myers, President, *presiding* (Fillmore and Van Buren Rooms).

Invocation—Mrs. William T. Lawson.

Pledge of Loyalty—Mrs. D. E. Greeneltch.

Welcome—Mrs. George A. Curry.

Response—Mrs. L. Dale Simmons.

Introduction of Honor Guests.

Presentation of Richard E. Flood, M. D., President, West Virginia State Medical Association.

Introduction of Convention Chairmen—Mrs. Pat A. Tuckwiller and Mrs. C. R. Davisson.

Roll Call of Delegates—Mrs. Joe N. Jarrett.

Convention Rules of Order—Mrs. D. E. Greeneltch, Parliamentarian.

Treasurer's Report—Mrs. J. Dennis Kugel.

In Memoriam—Mrs. Myer Bogarad.

Credentials and Registration—Mrs. James P. Baker.

Keynote Address—Mrs. Karl F. Ritter, President, Woman's Auxiliary to the American Medical Association.

Recommendations from Pre-Convention Board Meeting—Mrs. Hu C. Myers.

New Business and Announcements.

Report of Revisions Committee.

Report of Nominating Committee, First Reading, Mrs. Wilson P. Smith, Chairman.

Election of 1968 Nominating Committee.

Reports from Officers and Standing Committee Chairmen Will Not be Read As They Were Published in the Annual Reports Book.

Presentation of County Presidents by the Vice Presidents:

First Vice President, Mrs. Robert Tchou.
Second Vice President, Mrs. C. B. Buffington.
Third Vice President, Mrs. Richard Starr.
Fourth Vice President, Mrs. Robert W. Bess, Jr.

THURSDAY AFTERNOON

12:30—Past President's Luncheon, Mrs. Wilson P. Smith, Immediate Past President, *presiding* (Director's Room).

2:00—Medicine and Religion Program: "The Physician's Dilemma in the World of Changing Attitudes Toward Morals" (Governor's Hall).

Moderator: The Rev. Dr. Paul B. McCleave, Director, AMA Department of Medicine and Religion.

The Most Rev. Joseph Brunini, Apostolic Administrator, Catholic Diocese of Natchez-Jackson, Mississippi.

Milford O. Rouse, M. D., President, American Medical Association.

(Auxiliary Members are Invited and Urged to Attend).

THURSDAY EVENING

9:30 to 12:30—Anniversary Ball, Arranged by the Auxiliary to the Raleigh County Medical Society (Chesapeake Hall).

FRIDAY MORNING

August 25

9:30—Second General Session, Mrs. Hu C. Myers, President, *presiding* (Fillmore and Van Buren Rooms).

Introduction of Honor Guests.

Address—Mrs. C. T. Wilkinson, President, Woman's Auxiliary to the Southern Medical Association.

Presentation of Mrs. Chester Young, National AMA-ERF Chairman.

Presentation of Mrs. Frank Gastineau, AMPAC Representative.

Presentation of Mrs. William B. Walsh.

Report of Reading Committee.

Convention Announcements—Mrs. Pat A. Tuckwiller.

Reports of Convention Committees:

Finance—Mrs. Harry E. Beard.

Courtesy Resolutions—Mrs. Robert J. Tchou.

Credentials and Registration—Mrs. Eugene J. Morhous.

Press and Publicity—Mrs. L. Dale Simmons.

Report of Nominating Committee, Second Reading, Mrs. Wilson P. Smith, Chairman.

Election of Officers.

Report of President.

Installation of Officers—Mrs. Karl F. Ritter, President of the Woman's Auxiliary to the American Medical Association.

Presentation of President's Pin and Gavel—Mrs. Hu C. Myers.

Presentation of Past President's Pin—Mrs. Wilson P. Smith.

Inaugural Address—Mrs. Rupert W. Powell.

Announcements.

Adjournment.

FRIDAY AFTERNOON

2:00—Bridge Party, Arranged by the Auxiliary to the McDowell County Medical Society.

2:00—Golf Tournament, Arranged by the Auxiliary to the Logan County Medical Society.

FRIDAY EVENING

6:30—Cocktail Party.

7:30—Centennial Banquet and Ball (Chesapeake Hall).

SATURDAY MORNING

August 26

10:00—Post-Convention Conference and Board Meeting. Mrs. Rupert W. Powell, President, *presiding* (Fillmore and Van Buren Rooms).

SATURDAY AFTERNOON

2:30—Second and Final Session of the House of Delegates of the State Medical Association (Chesapeake Hall).

Presidential Address by Richard E. Flood, M. D., President of the West Virginia State Medical Association.

Installation of Richard V. Lynch, Jr., M. D., as President of the West Virginia State Medical Association.

(Auxiliary Members are Invited and Urged to Attend).

SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring the Officers of the West Virginia State Medical Association (Chesapeake Hall Terrace).

No Auxiliary Registration Fee

No registration fee will be assessed against either members or guests in connection with the 43rd Annual Meeting of the Woman's Auxiliary to the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 24-26, 1967.

SCIENTIFIC EXHIBITS

WEST VIRGINIA DEPARTMENT OF HEALTH

MULTIPHASIC SCREENING PROGRAM—A demonstration service to physicians attending the Annual Meeting.

The screening will include objective tests that could be made available to populations (rural and urban) in West Virginia. They will include a battery of blood chemistry tests done by use of the autoanalyzer of the State Hygienic Laboratory and other tests designed to provide the physician with physiological data to be used in the health appraisal of the patient. Electrocardiograms will be transmitted by telephone from the site at The Greenbrier to Washington, D. C., to the U. S. Public Health Service computer for rapid analysis and interpretation, the results of which will be returned to the meeting site. An opportunity will be offered to the physicians of the State to observe this modern diagnostic method and to ask questions concerning its operation. All physicians are invited to participate both as subjects and as students.

N. H. Dyer, M. D., Director, and I. E. Buff, M. D.

THE ARTHRITIS FOUNDATION VIRGINIA-WEST VIRGINIA CHAPTER

Many cases of arthritis require multiple treatment and support as well as close personal attention. The team concept, including a subprofessional aide or assistant, is a method of providing this care. The structure, function and evaluation of such a method applied at the Charleston Memorial Hospital Arthritis Clinic is presented in graphic fashion.

Daniel Hamaty, M. D., Seigle W. Parks, M. D., and Mrs. Jean Gardner.

AMERICAN MEDICAL ASSOCIATION DEPT. OF MEDICINE AND RELIGION

Literature will be available on the American Medical Association's Medicine and Religion Program, and a field representative will be in attendance for discussion.

Robert L. Coons, Field Representative.

THE NATIONAL FOUNDATION MARCH OF DIMES

"Chromosome 21"—This exhibit pictorializes Chromosome 21 and its association with Down's syndrome (Mongolism), and covers standard trisomy, translocation, mosicism and clinical aspects of Down's syndrome. A six-page illustrated booklet is available.

Jon W. Lipps and G. William Trout, Field Representatives.

WEST VIRGINIA ASSOCIATION OF MEDICAL ASSISTANTS

Literature will be available concerning the Association, its goals, advantages to both the doctor and the medical assistant, and the many educational programs available.

Mrs. Lyda Plymale, Educational Director.

THE DEMONSTRATION OF MALIGNANT CELLS IN THE CIRCULATING BLOOD

The exhibit deals with the methodology and morphology of cancer cells isolated from the peripheral blood. The four principal methods of separating cancer cells from the red blood cell mass and the white blood cells by physical and chemical methods are demonstrated. Experiments concerning the accuracy of the various methods using blood samples of healthy individuals seeded with cancer cells are shown. Our results on cadaver blood of patients dying with widespread cancer and on blood of patients with bronchogenic carcinoma obtained during surgery are given. The exhibit also includes a series of cases which will permit the comparison of cancer cells found in the blood stream with the cells of the original tumor and samples of atypical normal cells found in large blood samples.

John K. Frost, M. D. and David H. Hollander, M. D., Baltimore; Emmerich von Haam, M. D., and Thomas D. Stevenson, M. D., Columbus; and Alvin L. Watne, M. D., Morgantown.

WEST VIRGINIA DIVISION OF VOCATIONAL REHABILITATION

"A Pictorial Look at Vocational Rehabilitation"—This exhibit includes several color photographs that will graphically illustrate the various rehabilitation facilities and services offered by the Division. Personnel will be on hand to distribute state and federal vocational rehabilitation literature and to answer any questions concerning the program of rehabilitating the physically and mentally handicapped.

Thorold S. Funk, Director.

SOCIAL SECURITY ADMINISTRATION

"Disability and The Medical Report"—This exhibit emphasizes the need in connection with Social Security disability claims for objective descriptions of impairments, chronological history, physical and clinical findings, and diagnosis to be used by other doctors in reaching a disability decision.

G. D. Sherrill, M. D., Charleston, and Thomas Smith and James H. Swaim, Covington, Virginia.

PROGRESS IN CARDIAC VALVULAR DESIGN

This exhibit portrays a series of valvular prostheses of different types, including modifications of the discoid prosthesis, with specific design characteristics which are demonstrated by cross-sectional drawings and the hemodynamic characteristics are shown. Factors influencing thrombus formation and valve dislodgement are also portrayed. The results of research work on an anti-thrombogenic coating "Hepacone" are presented statistically and with color photographs. A new single unit tri-leaflet valve for aortic valve replacement will portray and introduce an entirely new concept in valvular design. The base of the valve follows the normal scalloped contour of the aortic annulus to permit rapid fixation with few sutures.

Charles A. Hufnagel, M. D., Washington.

WEST VIRGINIA SOCIETY OF INTERNAL MEDICINE

The West Virginia Society of Internal Medicine exhibit is composed of the official seal of the Society, and on the table will be displayed various pamphlets and other helpful information for members of the Society and other interested physicians. The West Virginia Society of Internal Medicine is a charter member of the American Society of Internal Medicine, which now has almost 9,000 internists as members.

Jack H. Baur, M. D., President.

MINIMIZING THE MENOPAUSE

There is a growing realization that it is both morally and medically justifiable to make what has become almost half of a woman's life comfortable, healthy and productive. The rationale of regarding the menopause as a deficiency disease is presented. Adequate replacement therapy with estrogen and progesterone will minimize its multiple disorders, such as: insomnia, depression, arthralgia, fatigability, incontinence, sweating, emotional instability, senile vaginitis, headache and hot flashes. A compilation of results achieved in patients in private practice in reducing the severity of these most frequent symptoms is graphically presented.

F. P. Rhoades, M. D., Detroit.

SOUTHERN MEDICAL ASSOCIATION

This exhibit describes the educational features supported by the Southern Medical Association, such as *The Journal* and the Annual Meeting. It also points out the advantages of membership in the SMA.

Mrs. Martha Hooks, Administrative Assistant.

CHARLESTON MEMORIAL AND GENERAL HOSPITALS

(Section on Urology)

"Genito-Urinary Tuberculosis: X-ray Demonstrations of Five or More Years Follow-up"—This exhibit presents serial x-rays of proven tuberculosis of genito-urinary tract observed over a period of five years or longer. Standard triple drug was therapy used in all cases when tolerated. Some good and some poor results are presented with explanations.

Donald R. Gilbert, M. D., and the Urological Staff.

OHIO STATE UNIVERSITY COLLEGE OF MEDICINE CENTER FOR CONTINUING MEDICAL EDUCATION

"Ohio Medical Education Network"—Here is an exhibit depicting a network of FM radio stations and hospitals in Ohio, Pennsylvania, Kentucky, and West Virginia which broadcasts *"live" two-way discussions* between home-community physicians and medical school faculty on vital problems of health. In response to the need for getting findings and applications of research from teaching centers to the practicing physician and his patient, the Center for Continuing Medical Education at the Ohio State University created this network, which in five years has conducted nearly 400 two-way programs and has expanded to television and nursing as well as medicine.

Robert B. Schweikart, Ph. D., Director of Communications.

NATIONWIDE INSURANCE COMPANY

"Part B Carrier's Role in Medicare" is briefly described in the display and further expanded in a pamphlet which will be available at our booth. The booth will be in the charge of Mr. R. N. Campbell, Medicare Manager of West Virginia, and other experienced Nationwide Medicare personnel will be available to answer general and specific Medicare inquiries during convention exhibit hours.

R. N. Campbell, West Virginia Medicare Manager.

AMERICAN CANCER SOCIETY W. VA. DIVISION, INC.

This exhibit highlights the extent to which unproved cancer therapy affects cancer victims throughout the nation despite the high level of scientific medicine practiced today. A series of photographs shows some of the harmful results of such therapy. The principal centers of unproved cancer therapy during the past 10 years, indicated on a map of the United States, illustrate that it is a nationwide problem.

William A. Nichols, Executive Director.

All Physicians and Guests

Attending the 100th Annual Meeting of the

West Virginia State Medical Association

Are Cordially Invited to Attend

A Special Medicine and Religion Program

Featuring a Discussion of

"The Physician's Dilemma in the World of Changing Attitudes Toward Morals"

Governor's Hall at The Greenbrier, White Sulphur Springs

Beginning at Two O'Clock

Thursday Afternoon, August 24

PARTICIPANTS

The Rev. Dr. Paul B. McCleave
Chicago, Illinois
Director, AMA Department of Medicine and Religion
Moderator

Milford O. Rouse, M.D., President
American Medical Association
Dallas, Texas

The Most Rev. Joseph B. Brunini
Apostolic Administrator
Catholic Diocese of Natchez-Jackson
Mississippi

INDUSTRIAL EXHIBITS

ABBOTT LABORATORIES
North Chicago, Illinois

Booth 7

Abbott Laboratories will feature three or four of its most important drug entities, along with several new specialty items of interest to physicians attending the meeting.

Representatives: James C. Weis and Donald Ford.

BRISTOL LABORATORIES
Syracuse, New York

Booth 18

CIBA PHARMACEUTICAL CO.
Summit, New Jersey

Booth 8

CIBA Professional Service Representatives will be pleased to discuss Ser-Ap-Es.

Representatives: R. O. Higham and H. W. Minetree.

THE COCA-COLA COMPANY
Atlanta, Georgia

Booth 42

Ice cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of Clifton Forge, and The Coca-Cola Company.

GEIGY PHARMACEUTICALS
Yonkers, New York

Booth 16

Geigy Pharmaceuticals cordially invites members and guests of the Association to visit its exhibit. The exhibit features important new therapeutic developments in the management of cardiovascular disease as well as current concepts in the control of inflammation; hypertension and edema; depression; obesity, and other disorders, which may be discussed with representatives in attendance.

HOSPITAL & PHYSICIANS SUPPLY CO.
Charleston, West Virginia

Booth 45

ELI LILLY AND COMPANY
Indianapolis, Indiana

Booth 43

You are cordially invited to visit the Lilly exhibit. Our sales representatives in attendance welcome your questions about Lilly products. You may be particularly interested in discussing Keflin® Sodium Cephalothin.

Representatives: Jim Risch and Bill Saylors.

S. E. MASSENGILL COMPANY
Bristol, Tennessee

Booth 2

Best wishes to the members of the West Virginia State Medical Association. Stop by our booth and say hello to "Bob" Kosnoski and "Skinny" Cobb. They will welcome your visit, and will be pleased to show you a *new* Massengill product.

Representatives: L. M. Cobb, Jr., and Bob Kosnoski.

McLAIN SURGICAL SUPPLY, INC.
Charleston, West Virginia

Booth 19

MEAD JOHNSON LABORATORIES
Evansville, Indiana

Booth 21

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

MEDICAL ARTS SUPPLY COMPANY
Huntington, West Virginia

Booth 41

We cordially invite all the members and guests of the Association to visit our exhibit, where we will feature the Unimeter. The *proven* Unitest System is a dependable, accurate and profitable diagnostic tool now in use in hundreds of doctors' offices. It is designed for use in your office by your present assistants for the five basic tests: true glucose; hemoglobin; cholesterol; urea nitrogen (BUN); and uric acid. We will also have various other items of diagnostic equipment that we are sure will be of interest to you.

Representatives: Larry Clovis and Roy Childers.

MERCK SHARP & DOHME
West Point, Pennsylvania

Booth 13

The Merck Sharp & Dohme exhibit has been designed to supplement the physician's therapeutic armamentarium. Technically trained personnel are present to discuss the scope and variety of services offered.

Representatives: Henry C. Hovey and Albert V. Ohlendorf.

ORTHO PHARMACEUTICAL CORPORATION
Raritan, New Jersey

Booth 30

Welcome to Booth 30, where Ortho is proud to present the three latest products of the Ortho Research Foundation, Ortho-Novum 2 mg. Tablets, Ortho-Novum Sq Tablets, and Delfen Vaginal Cream and Foam. Also on display will be our well-known products for the treatment of various forms of vaginitis. Your questions will be welcomed by representatives in attendance.

PARKE, DAVIS & COMPANY
Detroit

Booth 22

Medical service members of our staff are in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

Representatives: Mario Teza and R. K. (Bob) Hamilton.

PFIZER LABORATORIES
New York City

Booth 15

WM. P. POYTHRESS & CO., INC.
Richmond, Virginia

Booth 3

The Poythress exhibit will feature Trocinate, a unique, direct-acting (musculotropic) antispasmodic drug, and the Mudrane combinations, established Poythress products for relief of bronchial asthma. Solfoton, Solfo-Serpine, Panalgesic and Synirin will also be featured. Your requests for literature and professional trial quantities are cordially invited.

A. H. ROBINS COMPANY
Richmond, Virginia

Booth 32

You are cordially invited to visit the Robins display and meet our representatives who will welcome the opportunity to discuss products of interest with you.

Representatives: Ed Buck and Gus Addington.

ROCHE LABORATORIES
Nutley, New Jersey

Booth 24

Continuing Roche research has produced outstanding contributions to medicine since 1909. The personnel at the exhibit welcome your comments, questions or suggestions about our products and services.

Representatives: Luther Pratt and Jerry Gillen.

J. B. ROERIG AND COMPANY
New York City

Booth 5

J. B. Roerig & Company will welcome members of the medical profession at the Company's exhibit of leading specialty products. Representatives will be in attendance to answer any questions you may have. Roerig recently introduced a number of new products which representatives at the exhibit will be pleased to discuss with you.

ROSS LABORATORIES
Columbus, Ohio

Booth 11

Ross Laboratories presents three pediatric product lines plus current medical services: 1. Similac® Infant Formula Products, featuring Similac Isomil™ and Similac® 20 in Nursing Bottles. 2. Pediamycin™, cherry-flavored oral antibiotic effective against the common bacterial infections in children. 3. Vi-Daylin® pediatric vitamins formulated in accordance with Recommended Dietary Allowances of the NRC.

Representatives: Michael Smith, John Winnenberg and Joe Salonick.

SANDOZ PHARMACEUTICALS
Hanover, New Jersey

Booth 12

Sandoz Pharmaceuticals cordially invites you to visit our display at Booth 12, where we are featuring Mellaril, Sansert, Cafergot P-B, Fiorinal and Fiorinal with codeine. Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

Representative: Danny Williams.

W. B. SAUNDERS COMPANY
Philadelphia, Pennsylvania

Booth 44

Saunders will have on display a complete line of its medical books, including many new titles and editions, such as: White and Donovan, *Hearts, Their Long Follow-up;* Conn, *1967 Current Therapy;* Beeson and McDermott, *Textbook of Medicine;* Novak and Woodruff, *Gynecologic and Obstetric Pathology;* Murphy, *Radiation Therapy;* and many others.

Representative: J. Perry Duncan.

SCHERING CORPORATION
Union, New Jersey

Booth 20

Schering Corporation invites you to visit its exhibit, Booth 20, where its representatives will be available to discuss with you any questions you may have on Etrafon®, Afrin®, Garamycin®, Celestone®, Solus-

pan® Injection, Tinactin® or any other Schering product.

Representatives: Jack Rogers, John Carpenter and Charles Carter.

THE STUART COMPANY
Pasadena, California
Booth 26

A cordial invitation is extended to all members and guests attending this meeting to visit The Stuart Company booth. Specially trained representatives will be in attendance to answer your questions on new products, developed in our modern laboratories, which have particular interest for the medical profession. Products featured are Dialose, Dialose Plus, Ferancee, Mulvidren-F, Mulvidren Junior, Mylanta, Mylicon, Stuart Prenatal.

Representatives: Arthur C. Mackail and Paul C. Jones.

E. R. SQUIBB & SONS
New York City
Booth 27

STATE MEDICAL DISABILITY
Charleston, West Virginia
Booth 31

THE UPJOIIN COMPANY
Kalamazoo, Michigan
Booth 23

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

U. S. VITAMIN & PHARMACEUTICAL CORP.
New York City
Booth 25

WARREN-TEED PHARMACEUTICALS, INC.
North Chicago, Illinois
Booth 7

WILLIAM H. RORER, INC.
Ft. Washington, Pennsylvania
Booth 14

WYETH LABORATORIES
Philadelphia, Pennsylvania
Booth 28

Wyeth will feature . . .
Omnipen® (ampicillin) Wyeth
Equagesic® (meprobamate and ethoheptazine citrate with aspirin) Wyeth, Tablets
Full information is available at Booth 28.

Representatives: W. R. Haislip, Jr., and Upshur Higginbotham, Jr.

Visit the Exhibits!

Plan to spend several hours in the Exhibit Center visiting the Industrial and Scientific Exhibits. They form an integral part of the over-all program and this is your opportunity to discuss with trained professional service representatives the new products and therapeutic developments.

Pharmaceutical houses spend millions of dollars annually in medical research. The trained medical representatives who will be in attendance at the meeting are interested in disseminating information about the new drugs and advanced techniques to practicing physicians.

Please take this opportunity to visit every booth and express your appreciation to our exhibitors for their continued cooperation and support.

You are invited to attend the . . .

VAN LIERE - UNIVERSITY DAY PROGRAM

At the 100th Annual Meeting of

The West Virginia State Medical Association

THE GREENBRIER

White Sulphur Springs, Saturday, August 26

At 10 A.M.

Honoring:

Edward J. Van Liere, M. D., Ph.D.
Dean Emeritus, WVU School of Medicine

Discussion Topic:

"Medical Education—Past, Present and Future"

Participants:

Clark K. Sleeth, M.D., Dean
WVU School of Medicine
Moderator

William A. Sodeman, M.D., Dean Emeritus
Jefferson Medical College
Philadelphia

John Parks, M.D., Dean
George Washington University
School of Medicine
Washington

Kenneth R. Crispell, M.D., Dean
Univ. of Virginia School of Medicine
Charlottesville

William S. Stone, M.D., Dean
Univ. of Maryland School of Medicine
Baltimore

Kinloch Nelson, M.D., Dean
Medical College of Virginia
Richmond

Charles A. Doan, M.D., Dean Emeritus
Ohio State University
School of Medicine
Columbus

ANNUAL REPORTS

Cancer Committee

The Cancer Committee of the West Virginia State Medical Association again functioned as a cancer coordinating committee for West Virginia during 1966-67. On November 13, 1966, it called a meeting in Charleston of representatives of the various state organizations having an interest in the cancer problem. The number of organizations invited was increased this year.

The West Virginia Association of Pathologists reported significant progress on its cervical cytology project and told of its efforts in extending this project to include sputum studies on a mass basis for the early detection of lung cancer.

The committee was informed that the Director of the Division of Vocational Rehabilitation will look with favor on requests for prostheses and services which would help rehabilitate those patients who have had disabling operations for cancer.

The Committee approved a request of the American Cancer Society, West Virginia Division, to increase its mailing list to the members of other health professions when such material would apply to its members. Several other items in relation to the cancer problem were discussed.

Another meeting of the Committee has been called for Wednesday, August 23, 1967, at The Greenbrier Hotel.

Respectfully submitted,

Hu C. Myers, M. D.,
Chairman.

Philippi,
June 23, 1967

Committee on Maternal Welfare

The meeting of the Maternal Welfare Committee of the West Virginia State Medical Association in conjunction with the Division of Maternal and Child Health of the West Virginia State Department of Health was called to order by the Chairman at the Daniel Boone Hotel, Charleston, West Virginia, at 11:00 A. M. on May 21, 1967. Those present were A. J. Villani, M. D., Chairman, and the following members: Clarence H. Boso, M. D., Frederick H. Dobbs, M. D., Secretary, N. W. Fugo, M. D., George L. Grubb, M. D., Edwin J. Humphrey, M. D., and Gates J. Wayburn, M. D. Clarence H. Boso, II, M. D., attended as a guest.

The Division of Maternal and Child Health of the West Virginia State Health Department was represented by Frederick H. Dobbs, M. D., Obstetric Consultant.

The Chairman expresses his appreciation for the splendid cooperation of all members of the Committee and especially to the interested members who attend all meetings. They review the abstracts of maternal deaths and formulate the policies, thus maintaining the high standard of obstetric practice which has been the mark of this Committee's work. The members attending the meetings represent the interested obstetricians who are professionally qualified to review the case abstracts, to understand the facts contributing to each maternal death and to make intelligent recommendations for the benefit of the interested physicians and the edification of the physicians who practice obstetrics in the State.

Physicians having a maternal death willingly forward complete prenatal records, with the data on hospital admission, delivery, and the developed complication, forwarded with laboratory data, consultants records, operative records and autopsy reports. The Maternal Welfare Committee is interested in one thing: to increase the standards of obstetric practice among the physicians of the State. This data is abstracted as a hypothetical case and the name of the patient, physician and hospital is confidential, known only to the Secretary and his departmental secretary.

The Record Librarians have cooperated splendidly in furnishing complete copies of nurses' notes, operative records, autopsy reports, anesthesia charts, laboratory data and consultant's records. When all this data is available, it is easy to follow the course of the patient from the time she became pregnant, to the time she was admitted in labor or admitted with a complication. A close chronological pattern develops in each maternal death and this can be followed until the patient expires. The cause of death is confirmed by autopsy, but this is not always available (see XIV).

The Bureau of Vital Statistics, under the direction of Dr. N. H. Dyer and Mr. Paul Shanks, is the primary source of our maternal death records. All death certificates of women dying in the childbearing age are checked by a special clerk who refers all certificates having any relation to pregnancy to the Secretary for his scrutiny. If the death certificate is classified as related to pregnancy, letters are written and a questionnaire is forwarded to the interested physician. In borderline cases, a letter is written for clarification.

The successful employment of the several methods of contraception, especially the oral contraceptives and the IUD, together with our loss of population in the childbearing age, has brought our total births to a new low of 31,958 for 1965. The highest total births for one year was in 1947 with a little over 50,000 births recorded. Funds are now available for the establishment of birth control clinics throughout the State. Many of these clinics will be implemented during the coming year and emphasis will be placed on family planning as an incorporate part of continuing comprehensive care.

It is an interesting fact that general practitioners in many of our urban areas have given up the practice

of obstetrics and are referring these cases to the specialist. If this trend continues, the specialist will indeed deliver the majority of the parturients and this alone should increase the standard of practice, especially in the conduct of the complicated patient.

TABULATED ANALYSIS OF COMMITTEE'S WORK

The following tables contain the tabulated analysis of the work of the Committee for the current year and these studies are submitted for the information of and study by the members of the West Virginia State Medical Association.

The latest statistical survey for West Virginia between maternal deaths and births is for 1965. In that year there were:

Total Births	31,958
Maternal Deaths	14
Maternal Death Rate	.4

MATERNAL DEATHS, JULY 1, 1966—JUNE 30, 1967

I. Classification of Maternal Deaths Reviewed by Committee During the Period of July 1, 1966—June 30, 1967

Year	*Maternal*
1966-1967	11

II. Maternal Deaths by Cause (1966-1967)

Cause of Death	*No.*	*% of Total*
Direct		
Amniotic Fluid Embolism-Septicemic Shock	1	9.1
Ruptured Uterus-Amniotic Fluid Embolism	1	9.1
Septicemic Shock	1	9.1
Anesthesia—(Oxytoxic)	1	9.1
Renal Failure	1	9.1
Pulmonary Embolism	1	9.1
Bronchopneumonia (Hepatic Coma)	1	9.1
Peritonitis—Occult Rupture of Uterus	1	9.0
Total	8	
Indirect		
Salmonella Typhimurium	1	9.1
Septicemia-Acute Yellow Atrophy	1	9.1
Subacute Bacterial Endocarditis	1	9.1
Total	11	100.0

III. Maternal Deaths by Preventability (1966-1967)

Classification	*No.*	*% of Total*
Preventable by Physician	4	36.3
Preventable by Patient	2	18.2
Non-preventable	5	45.5
Total	11	100.0

IV. Maternal Deaths by Place of Delivery (1966-1967)

Place	*No.*	*% of Total*
Hospital	9	81.8
Undelivered	2	18.2
Total	11	100.0

V. Maternal Deaths by Race (1966-1967)

Race	*No.*	*% of Total*
White	11	100.0

VI. Maternal Deaths by Age Groups (1966-1967)

Age Groups	*No.*	*% of Total*
15-19	1	9.1
20-24	3	27.2
25-29	1	9.1
30-34	3	27.2
35-39	2	18.3
40-44	1	9.1
44 Plus	0	0
Total	11	100.0

VII. Maternal Deaths by Parity (1966-1967)

Parity	*No.*	*% of Total*
Primapara	1	9.1
1-3	8	72.7
4-6	1	9.1
7 and over	1	9.1
Total	11	100.0

VIII. Maternal Deaths by Weeks of Gestation (1966-1967)

Weeks of Gestation (Lunar Months)	*No.*	*% of Total*
Less than 28 weeks	0	0
28-33 weeks	2	18.2
34-39 weeks	3	27.2
40 weeks plus	6	54.6
Total	11	100.0

IX. Maternal Deaths by Operative Procedure (1966-1967)

Procedure	Pre-ventable	%	Non-Prevent-able	%
None	3	27.2	7	63.7
Caesarean Section	1	9.1		

X. Maternal Deaths by Type of Consultation (1966-1967)

Type of Consultant		*% of Total*
Surgeon	5	Percentage cannot be calculated because some patients were seen by more than one consultant. But it is significant that only 27.2% had no consultation.
Obstetrician	3	
Internist	4	
Public Health	1	

XI. Interval Between Delivery and Death (1966-1967)

Time Interval	*No.*	*% of Total*
Under 1 day	4	36.4
1 day - 1 week	2	18.2
1 week plus	3	27.2
Undelivered	2	18.2
Total	11	100.0

XII. Outcome of Pregnancy in Maternal Deaths (1966-1967)

Type of Outcome	*No.*	*% of Total*
Livebirth—full term	5	45.6
Livebirth—Premature	1	9.0
Stillbirth	3	27.2
Not delivered	2	18.2
Total	11	100.0

XIII. Analysis of Maternal Death Certificates (1966-1967)

	No.	*% of Total*
Death Certificate Correct and Complete	8	72.7
Incorrect	3	27.3
Total	11	100.0

XIV. Autopsies done on Maternal Deaths (1966-1967)

	No.	*% of Total*
Autopsy obtained	4	36.4
Autopsy not obtained	7	63.6
Total	11	100.0

Definitions

1. *Maternal Death*—The death of any woman dying of any cause whatsoever while pregnant or within six months of the termination of the pregnancy, regardless of the duration of the pregnancy at the time of the termination or the method by which it was terminated.
2. *Direct Obstetric Cause of Death*—A death resulting from complications of the pregnancy itself, to intervention elected or required by the pregnancy or resulting from the chain of events initiated by the complication or the intervention.
3. *Indirect Obstetric Cause of Death*—A death resulting from disease before or developing during pregnancy (not a direct effect of the pregnancy) which was obviously aggravated by the physiological effects of the pregnancy and caused the death.
4. *Non-Related Cause of Death*—A death occurring during pregnancy or within 90 days of its termination from causes not related to the pregnancy nor to its complication or management.
5. *Factors of Preventability (Avoidability)*—Preventability should be judged in an ideal academic sense. This concept involves three assumptions. First, the physician possessed all the knowledge currently available relating to the factors involved in the death. Second, by experience, he had reached a high level of technical ability. Third, he had available to him all the facilities present in a well-organized and properly equipped hospital. Because of the austerity of these criteria, it is more desirable to determine avoidable factors involved in the death, rather than to label the death as preventable. This allows more specific discussion resulting in better maternal care and reduction of obstetric causes of death.
6. *Factors of Responsibility*—Responsibility should be determined whenever possible and assigned as appropriate to the attending physician, consultant, midwife, hospital, patient, or any combination.

Factors

A. *Professional Factors*—These are concerned with cases where there appear shortcomings in diagnosis, judgment, management, and technique, and include failure to recognize the complication or evaluate it properly. They also include instances of injudicious haste, delay or timing of operative intervention, and failure to utilize currently acceptable methods of treatment. Finally, they would include services which were technically inept, and those failures which could have been averted by proper and timely consultation.

B. *Hospital Factors*—These are concerned with facilities, equipment, or personnel which are inadequate. In terms of modern obstetrics the hazards of delivery cannot be met successfully unless the hospital provides, (1) a separate, well-directed maternity section; (2) a blood bank; (3) competent 24-hour anesthesia service; (4) suitable x-ray facilities; and (5) adequate 24-hour laboratory facilities.

C. *Patient Factors*—These should be recognized, but never as an excuse for professional inadequacy. They are concerned with death resulting from a complication for which there is generally successful treatment but which the patient denied herself by delaying her initial visit to the physician, delaying obtaining medical care after the symptoms were obvious at a layman's level, or finally, by not following the advice and instructions of her physician.

D. *Undetermined Factors*—If because of inadequate evidence a clear-cut decision cannot be made, yet short-comings in care are apparent, it would be preferable to indicate that responsible factors are undetermined. An attempt should be made to determine preventability and to locate the responsible factors.

Analysis of Maternal Deaths

The Committee then proceeded to the analysis of eleven maternal deaths with the following conclusions:

1. There were eight maternal deaths from direct obstetric causes and three maternal deaths from indirect obstetric causes.

   There were three cases of amniotic fluid embolism, two of them complicated by septicemic shock and the third complicated by uterine rupture. There were two cases of uterine rupture with hemorrhage, and the remaining were an interesting variety of causes and it is in this category that the preventable factors are the most frequent. For example:

   A. *Amniotic fluid embolism complicated by septicemic shock.*

   A white (non-married) female, age 35, a Gravida 3 Para 2, was admitted to the hospital with vaginal bleeding. The patient was 37 weeks in her third pregnancy. The patient was obese, weighing 202 pounds, but her prenatal course was normal. She was A-Negative. She had hepatitis four times. She had an appendectomy and a cholecystectomy with transfusions. The first full term pregnancy delivered normally in 1948; the second pregnancy delivered normally in 1956, an 11 lb. 10 oz. male which lived only a few minutes. She required multiple transfusions, the complication for which was not documented. The patient began spotting the 35th week and was admitted for observation. She was discharged on the 6th hospital day. She was admitted six days later when she had a sudden gush of vaginal bleeding. An hour after the bleeding began, she had a sudden gasping for air, became deeply cyanotic and began thrashing around on the bed and had to be restrained. She then had tonic and clonic convulsions and developed difficulty in breathing. An airway was established and the patient was resuscitated with positive pressure on the bag and external cardiac massage. With the next convulsion she developed acute respiratory distress and had brisk vaginal bleeding. The pulse and blood pressure were not obtainable. Multiple cutdowns, intubation with bag breathing gave no patient response. After a double set-up examination, a Braxton-Hicks version was done to tamponade the placenta praevia in an effort to save the patient's life. The patient developed petechiae of the face, neck and chest; the apical beat was again lost, and she expired 3½ hours from the beginning of her first symptoms, and 2½ hours from the time she collapsed in extremus from which she never did recover.

B. *Ruptured uterus resulting in amniotic fluid embolism.*

A 31-year-old female, a Gravida 4 Para 3, was admitted to the hospital in active labor with some bloody show. The patient was in the 42nd week of her fourth pregnancy and the condition upon admission was considered good. The past obstetrical history was negative with the delivery of three infants, which are living and well. She had a cardiovascular complication following rheumatic fever but there was no carry-over into her adult life. Prenatal care was adequate. She gained 20 pounds. The blood pressure and urinalysis were all normal. She had one complication—that of spotting the last month. She began in labor at noon and was admitted at 4:30 P.M. with a bloody show. At 7:30 P.M., she had excessive bleeding and passed a small clot. At 8:30 P.M., the attending physician did an amniotomy and started her on minimum doses of Pitocin intramuscularly. She required sedation 10 minutes later and about 40 minutes later the heart tones stopped. She was removed to the delivery room where the physician attempted a manual dilatation of the cervix and dilated her from 6 cm. to complete dilatation. Following the manual dilatation, the stillborn fetus was delivered by low forceps over a median episiotomy. Almost immediately following the delivery of the placenta, the patient went into deep shock and expired in an hour. There was no autopsy.

C. *Septicemic shock—the result of labor.*

A 41-year-old white female, a Gravida 9 Para 8, was admitted to the hospital in the early first stage of her ninth pregnancy. The membranes had ruptured spontaneously at home and the condition of the patient upon hospital admission was considered only fair. Prenatal care was established in the fifth month with a total of seven office visits, but this was complicated by the fact that the patient could not hold oral medication and it was difficult to keep the hemoglobin up to satisfactory levels. She received two Imferon shots a week for the four weeks prior to admission. The complications noted in the prenatal area were hypertension, hyperemesis, pyelonephritis, and anemia. The patient was admitted in early first stage with the membranes ruptured. The hemoglobin on admission was 9.4 grams, albumin 10, and the microscopic showed 135-145 pus cells per hpf. (voided spec). The following day she had occasional pains and in the evening she complained of severe dysuria. A catheterized specimen revealed 125 mg. albumin and a trace of acetone, and a solid field of pus cells. She was treated with I. V. fluids and Chloromycetin intramuscularly. The following day she spiked a temperature to 102 degrees F. and began with hard labor pains and vomiting of a greenish fluid. The patient was taken to the delivery room and delivered a viable female fetus without incident or without anesthesia. The placenta delivered intact and complete. A small perineal laceration was repaired. The blood pressure was 150/90. Thirty minutes following delivery she had a severe chill and was given rectal aspirin. An hour later the temperature was 105 degrees. She was given an alcohol sponge, I. V. glucose 5/W and the blood pressure began to drop. In 30 minutes the pressure was 84/60. She received whole blood and the pressure rose to 90/62. In spite of heroic measures, the pressure continued to fall until she expired 5½ hours following delivery. A surgeon consultant felt she was suffering from irreversible shock due to a gram negative septicemia secondary to the urinary tract infection. There was no autopsy.

D. *Cardiac Arrest (anesthesia death from oversedation and overstimulation with Spartocin)*

A white female was admitted to the hospital in active labor. She was a 20-year-old Gravida 2 Para 1, and labor began spontaneously at home three hours prior to admission. The patient was considered full term in her present pregnancy and the condition upon admission was considered good. She had adequate prenatal care with a total of 10 prenatal office visits. Her past medical and surgical histories were negative. She delivered a viable 8 lb. 10 oz. fetus in 1964 which survives. She was admitted at 6:45 A.M. with contractions every five minutes, dilatation 2 cm., and station minus one. At 9:30 A.M., she ruptured her membranes spontaneously. At 10:40 A.M., she received Seconal gr. 1½ and slept for 2½ hours. At 1:00 P.M., the physician considered her labor desultory and he gave her Spartocin ½ ampoule I.M. At 1:45 P.M., she received Demerol mg. 50, Phenergan mg. 50 and Scopolamine amp 1. The cervix was dilated to 4 cm. at this time. At 3:35 P.M., the Spartocin amp ½, and the above sedation was repeated. At 4:05 P.M., she received Spartocin 1 amp. Dilatation was 6 cm. At 5:00 P.M. she received Dramamine mg. 100 and Scopolamine amp ½ I.M. At 5:17 P.M. she received Spartocin amp 1 I.M. She was 8 cm. dilated. At 5:45 P.M. she was removed to the delivery room where she received Pitocin m 1, I.M. 6:00 P.M. anesthesia was started and at 6:25 P.M. she delivered a viable male fetus weighing 10 lbs. While placing the fetus in a crib, the anesthetist reported that the patient had stopped breathing. The patient was intubated and "breathed" on a bag but there was no response to this or to the numerous stimulatory drugs given. The patient was pronounced dead at 7:15 P.M. There was no autopsy.

E. *Renal failure complicated by severe obesity.*

A white female, age 23, a Gravida 7 Para 6 Abortus 0, was admitted to the hospital apparently at full term in her seventh pregnancy. The patient was bleeding without uterine contractions or dilatation. She was hypertensive; urine output was diminished and she had the symptoms of severe preeclampsia. She had four prenatal office visits beginning with the sixth month. The blood pressure was 140/70. The patient gained 39 pounds and weighed 240 pounds. The urinalysis was negative but her hemoglobin was 82 per cent and the RBC 4,010,000 and WBC 8,200. She had a cardiovascular condition along with the severe obesity. In the almost four weeks from her last office visit to the time of admission, she had dizzy spells, severe edema of the feet and legs, and was admitted in poor condition. During this interval her output of urine was diminished. She developed severe and constant headaches, disturbances of vision and generalized edema. Vaginal bleeding continued after admission, so consultation with an obstetrician confirmed the diagnosis of placenta ablatio, and a cesarean section was performed. The fetus and patient survived the operative procedure but during the next five days, the hospital course of the patient was downhill. She developed myocardial failure and uremia. She received several courses of diuretics and magnesium sulfate but there was no patient response to therapy. The patient expired six days after her hospital admission and five days following the cesarean section. There was no autopsy.

F. *Pulmonary embolism.*

A white female, age 22, a Gravida 3 Para 2, was admitted to the hospital in active labor. The patient was 43 weeks in her third pregnancy and the fetus had perished in utero five days prior to admission. The patient was exhibiting signs and

symptoms of toxemia and the attending physician attributed the fetal death to the toxemia. She received seven prenatal office visits. She gained 16¾ pounds up to 146¾ pounds. Her hemoglobin was 6.1 grams. Labor began at 6:00 A.M. and she was admitted at 6:45 A.M. in fair condition. The membranes ruptured spontaneously at 7:15 A.M., and at 7:30 A.M., she was removed to the delivery room. She had no examinations or sedation during the 1½ hours of the first stage.

A stillborn fetus was delivered at 7:45 A.M. over a median episiotomy but no forceps. The patient received Trilene with the episiotomy administered by a nurse anesthetist. The placenta delivered intact and complete at 8:00 A.M. Total time of labor was two hours. The patient was removed to her room and at 11:00 A.M., she developed a sudden severe pain in the chest and immediately expired. This was three hours after delivery and five hours after the beginning of labor. There was no autopsy.

G. *Indirect obstetric cause of death—Salmonella typhi-murium.*

A white female, a Gravida 4 Para 3, was admitted to the hospital for treatment of diarrhea. The patient was 37 weeks in her fourth pregnancy and the condition of the patient upon admission was considered fair. Prenatal care was established in the fifth month of her present pregnancy with a total of six prenatal office visits. The prenatal course was normal with normal weight gain, normal growth of the fetus, and normal urinary and hematology findings until the day of hospital admission when she developed nausea, vomiting, abdominal cramps and diarrhea. This became progressively worse until she was admitted. The first hospital day she ran a temperature of 103.4 degrees F., with nausea, cramps and diarrhea. The following day she continued with the cramps and diarrhea but no labor.

On the third hospital day, she went into active labor and in four hours delivered a viable fetus weighing 6 lb. 10 oz. (the newborn developed salmonella later but survived). Following delivery, she was removed from the OB floor and an attempt was made to isolate the offending organism. The State Health Department team isolated Salmonella typhi-murium. Two weeks following delivery, the patient continued with diarrhea, a distended abdomen, and was dangerously ill. An obstruction developed so the patient was operated and a cecostomy was done to decompress her. Twelve days later, after she had shown some improvement, she suddenly took a turn for the worse and expired. The autopsy confirmed the diagnosis and demonstrated the severe panperitonitis, necrosis, and perforation of the transverse colon and the abdominal wall abscesses.

H. *Bronchopneumonia, hepatic coma from acute alcoholism.*

A white, never married, female age 34, a Gravida 1 Para 0, was admitted to the hospital because of acute alcoholism. The patient was apparently in the 36th week of her first pregnancy but clinically the pregnancy appeared to be only 6½ months gestation. She drank a pint of whiskey that morning and she was admitted with edema of the ankles and legs, and a pregnancy which had perished in utero about 10 to 14 days prior to admission. The condition of the patient upon hospital admission was considered poor.

There were two office visits, one at 29 weeks when she received Serpasil and Thiomerin 2 c.c. for severe ankle edema. Her weight was 167 pounds and she was Rh negative. The patient had a past history of being an alcoholic for years but this was apparently her first pregnancy. The second office visit was at 33 weeks and the physician suspected fetal death in utero. Her weight was 165½ pounds. The urinalysis was again negative and an x-ray was ordered which was not carried out. She was seen three weeks later upon hospital admission when she was admitted in an intoxicated state and with severe edema. The x-ray taken immediately upon admission confirmed the diagnosis of fetal death in utero. She was then removed to the delivery room where she delivered a macerated fetus weighing 3 lb. 2 oz. The placenta was delivered intact and complete.

Two hours after delivery the patient had an involuntary bowel movement in bed. Three hours following this, she voided involuntarily in bed, and when they began to change the bed, the patient lowered her head and began to convulse. The patient became cyanotic, respirations ceased, and they were unable to get the blood pressure or pulse. She received cardiac massage, resuscitation and nasal oxygen. She responded and the pulse and heart beat was reestablished. Convulsions continued that evening and all during the night. Efforts were made to establish respirations, to control the convulsions and combat the anoxia. The EKG showed a sinus tachycardia and myocardial anoxia. The following day she continued to convulse and remain in a coma. The patient continued in this pattern of convulsions and coma for the next four days when she expired. There was no response to any medication. The autopsy confirmed the diagnosis of massive fatty metamorphosis of the liver and bilateral bronchopneumonia.

I. *Indirect obstetric cause of death was gram negative septicemia, acute yellow atrophy, acute renal failure and duodenal ulcer with gastric hemorrhage.*

A white married female, age 36, a Gravida 7 Para 2, Abortus 1, Premature 3 (expired), was admitted to the hospital at approximately 32 weeks in her seventh pregnancy with the membranes ruptured and leaking amniotic fluid. She had comprehensive prenatal care with a total of five prenatal office visits established in the third month. Her usual weight was 103 pounds and she gained 11 pounds. Urinalysis negative, Hb. 12.6 grams, Type A, Rh Positive. She had a past history of an active duodenal ulcer and a sliding hiatal hernia. In February 1966, she underwent a selective vagotomy, hiatal herniorrhaphy, and pyloroplasty.

She was admitted with the membranes ruptured 24 hours prior to admission. She was given oral penicillin and kept at bed rest. On the third hospital day she developed a chill and a temperature of 101 degrees F. This subsided. On the fourth hospital day, she went into active labor and had another chill with a temperature of 100.6 degrees F. A blood culture was drawn and the serum noted to be jaundiced. In two hours she delivered a premature viable male fetus weighing 4 lb. 1 oz. which survives. The placenta and membranes were delivered intact and complete. The newborn had pneumonia and a temperature of 100.8 degrees F. Four hours later she began to vomit dark blood which became profuse. She was immediately transfused and it was here that the past history came out that the patient had severe epigastric pain and she was controlling the pain and burning with AMT at home. This had been going on for the past two months but she never informed the obstetrician. A Levin tube was put down and the stomach irrigated with ice saline solution. She continued to bleed thru the tube but the thermal control soon stopped the hemorrhage. She then

began to hemorrhage vaginally and it was noted that the blood did not clot. Fibrinogen levels were obtained and it was found that the patient had afibrinogenemia. She received two units of Fibrinogen and the blood clotted immediately. During this therapy, it was noted that the patient developed anuria. An indwelling catheter was put in place but no urine was obtained. The liver began to be tender and enlarge and the patient was becoming jaundiced. The consultants felt she was developing a hepatorenal syndrome and in the face of no improvement, she was transferred to an urban hospital where an artificial kidney was available.

Additional laboratory data from the first hospital follows: The urine culture showed no growth after 72 hours. The hematocrit dropped to 31 grams with the hemorrhage, then rose to 37, then back to 34 grams. The fibrinogen level fell below 100 mg. per cent, but returned to normal levels with the administration of the fibrinogen. The white blood count dropped to 2,800 WBC with two nucleated RBCs, polychromasia, and metamyelocytes. The differential count showed 41 segs, 39 stabs, 19 lymphs, and one other cell. Just before her transfer the blood pressure dropped from 110/80 to 70-80/50, and the pulse was rapid varying from 100 to 130.

When the patient was admitted to the urban hospital, it was noted that she had an infected amniotic fluid which was foul smelling and a gram negative organism was cultured from the blood. On admission she was critically ill, with a blood pressure of 92/70 and a pulse of 100. The face was flushed and she was obviously jaundiced, and there was coffee ground material being aspirated from the naso-gastric tube. The liver was large and tender and the spleen edge was barely palpable and non-tender. Peritoneal dialysis was instituted but there was no output of urine and the BUN gradually rose to 138. In spite of heroic therapy, the patient's condition deteriorated and she became obviously a liver failure problem and had no urine output of any significance throughout the hospital stay. She gradually deteriorated and expired on the seventh day after her admission to the urban hospital and 10 days after delivery. There was no autopsy.

J. *Occult rupture of the uterus with acute peritonitis, multiple abdominal and subdiaphragmatic abscesses, subhepatic abscesses, acute bronchopneumonia.*

A white female, age 30, a Gravida 3 Para 2, was admitted to the hospital in mild active labor. The patient was in good condition and labor began spontaneously at home approximately five hours before admission. Prenatal care was established in the fourth month with a total of 12 prenatal office visits, which were all normal. She had toxemia with the first pregnancy and a postpartum hemorrhage with the second delivery but no complications were noted with the present pregnancy.

When she was admitted in active labor, her hemoglobin was 11.5 grams per cent and she was given Buccal Pitocin which was completed in four hours. Four hours later, while labor was continuing, she had an episode of shortness of breath, moderate amount of vaginal bleeding and lowering of the blood pressure to 70/50 and tetanic type of contractions which were relieved by Demerol 75 mg., intra-nasal oxygen, and I. V. fluids. Three hours later the cervix was completely dilated and she was removed to the delivery room. The total time of the first stage was 15 hours. In 24 minutes, she received a low spinal with Heavy Nupercaine 3.57 mg. administered by a resident and she delivered a viable fetus weighing 8 lb. 9 oz. The placenta was manually removed 30 minutes later. The patient received Methergine 1 c. c., I.M., and Pitocin 1 c. c., I.V., but the uterus did not contract well.

Immediately following this, the patient went into hypovolemic shock with no pulse and no blood pressure. Four units of blood pumped under pressure with Aramine, the patient was able to sustain an adequate profusing blood pressure on her own after receiving 300 mg. of hydrocortisone, I.V. After the patient recovered from her shock, she did well until the third postpartum day when she developed symptoms of small bowel obstruction. On the fifth postpartum day, she was taken to surgery where an exploratory laparotomy revealed adhesions of small bowel at a site of a hematoma in the right broad ligament. Exploration of the uterus revealed a small occult rupture below the insertion of the right round ligament which would not admit a fingertip. No active bleeding was found. An appendectomy and appendostomy was carried out to permit bowel decompression after lysis of the bowel adhesions.

The patient did well for the first nine postoperative days but on the tenth day she began showing signs and symptoms of acute peritonitis. On the fourteenth postoperative day, the patient was taken to the operating room and a ring forceps exploration revealed retained placental tissue with severe necrotic reaction occurring. A supracervical hysterectomy was performed and no abscesses were found. A culture taken at surgery revealed E. coli. She became progressively worse and developed a bowel fistula from the right lower quadrant with progressive signs of subdiaphragmatic and subphrenic abscesses. A left thoracentesis was done removing 900 c. c. of sterile fluid, and five days later a right thoracentesis was done removing 550 c. c. of fluid revealing E. coli and staph coagulase negative. Later she developed septicemic shock and expired. This was 70 days after hospital admission. The autopsy confirmed the clinical findings plus an extensive postpartum infarction of the anterior lobe of the pituitary with moderate bilateral adrenal cortical atrophy.

K. *The indirect obstetric cause of death was subacute bacterial endocarditis of the rheumatic mitral valve complicating pregnancy.*

A white married female, age 19, a Gravida 1 Para 0, was admitted to the hospital in extremis with acute bilateral lobar pneumonia which involved all five lobes. She was in lung failure on admission. She was seven months in her first pregnancy and was admitted because of fever, dyspnea, cough, and bloody sputum. She had a past history of a cold for three weeks for which she took "cold" tablets. Admission examination revealed a temperature of 104 degrees F., extreme dyspnea, tachycardia, rales present in all lung fields, cyanosis, pulsus alternans and a loud pan systolic murmur. The patient's course was downhill in spite of massive doses of antibiotics, fluids and digitalis. A tracheostomy was done but this gave no improvement. She expired 24 hours after admission and there was an autopsy.

Autopsy revealed subacute bacterial endocarditis involving rheumatic mitral stenosis. Pulmonary congestion and edema bilateral. Acute focal myocarditis.

Respectfully submitted,

A. J. Villani, M. D.,
Chairman

Welch,
June 16, 1967.

Insurance Committee

Our State Medical Association continues to sponsor one of the outstanding Group Insurance Programs in the country. Seven plans provide a wide scope of essential forms of personal protection including a Complete Disability Program, Life, Catastrophe Liability, Accidental Death and Dismemberment Insurance plans.

Participation continues at a very high level. More than 900 members now participate in the program.

Another essential factor in its continued success is Policy Holders Service. Our Resident Administrator maintains a qualified staff, completely specialized in Association Group Insurance. Claims are processed and paid here by our Resident Administrator. A service representative travels the State and is always on call for consultation on claims or other policy holders service. More than 19 years of experience has clearly demonstrated the value of this "On the Ground" service to our members.

The most significant development of the year is the introduction of the new "Portfolio of Insurance" (soon to be released). The new portfolio provides a visual index of coverages now available. Each plan is described in a separate brochure with a resumé of its coverage and cost. The portfolio also is a convenient place for safekeeping of Association Group policies now in force. Of greatest importance, the portfolio is personalized and provides each participant a survey of the policies he now carries and describes the plans for which he may apply.

In summary, our State Group Insurance Program operates at a very high level of performance. Members continue to express their satisfaction both with the diversification of coverages available and policy holders service .

Respectfully submitted,

C. A. Hoffman. M. D.,
Chairman
W. P. Bittinger, M. D.
Robert L. Chamberlain, M. D.
R. U. Drinkard, M. D.
Upshur Higginbotham, M. D.
Athey R. Lutz, M. D.
Kenneth G. MacDonald, M. D.
Buford W. McNeer, M. D.
L. J. Pace, M. D.
Andrew, J. Weaver, M. D.

Huntington,
July 5, 1967.

Medical Education and Hospitals

The Committee on Medical Education and Hospitals is pleased to report that its continuing medical education program will be launched in September.

Dr. D. Sheffer Clark of Huntington and others will present a course in cardiac auscultation on Saturday, September 9, at Herbert J. Thomas Hospital in South Charleston. Details have not been completed at this writing, but plans are to have a cardiologist from the West Virginia University School of Medicine assist Doctor Clark. Several internists from the Charleston area have been invited to assist as discussants.

Dr. Edwin M. Shepherd of Charleston, the Committee's Educational Coordinator for the Charleston Area, and Dr. Daniel Hamaty of Charleston have been working with Doctor Clark in making the arrangements.

The Headquarters Staff of the State Medical Association has been requested to promote this first program in what we hope will be a long series through mailings and announcements in *The Journal.*

Getting the postgraduate program off to a start has been the Committee's main concern since we last reported to the membership of the Association in 1966. The Committee's seven other Educational Coordinators have been asked to present detailed plans for programs in their own areas at our next meeting.

The Committee wishes to re-emphasize that the eight geographical regions it has drawn in the State are in no way restrictive. Every member of the Association is cordially invited to attend the program in South Charleston (Area 5) on September 9.

The Committee did considerable homework before proceeding with the postgraduate program. On November 13, 1966, we sponsored a Medical Education Planning Conference, which was well attended by both professional and lay representatives of public and voluntary health agencies, hospitals and other interested groups and organizations. From this conference we received pledges of support from many organizations and learned how they could assist us.

Early this year, each of our eight educational coordinators was asked to determine which hospitals in his area might be suitable loci for postgraduate education. Each acceptable hospital was surveyed as to available educational facilities, meeting rooms, projection equipment, live patients for demonstrations, etc. This information has been assembled and is now on file at the Headquarters Office.

We then prepared a medical education survey and sent it to 1,320 members of the State Medical Association. Among other things, this survey asked each physician to state the principal modalities of his postgraduate study; reasons, if any, he fails to keep abreast of medical developments; the general disease areas he thinks should be emphasized in the Committee's program; and how he thinks the Committee might best approach the problem.

The response to this survey was most gratifying. Almost half of the physicians completed the questionnaire and returned it. We think this demonstrates widespread interest in the postgraduate education problem. The answers were tabulated, studied and analyzed, providing the Committee with valuable information.

Also during the year, representatives of the Committee have been in communication with the West Virginia Advisory Committee for the Regional Medical Program for Heart Disease, Cancer and Stroke and

Related Diseases. It is felt that for the sake of efficiency, our postgraduate program might well be correlated with the plans of the Advisory Committee.

Respectfully submitted,

Pat A. Tuckwiller, M. D.,
Chairman

Charleston,
July 6, 1967

Committee on Medical Scholarships

The meeting of the Committee on Medical Scholarships was held at the Medical Center in Morgantown on Saturday and Sunday, April 22 and 23.

The first session was called to order at 2:15 P.M. at which time a critical evaluation and discussion was entered into by all the Committee in regard to possible changes which might be needed to make our program more effective. It was the consensus of the Committee that several years should elapse in order to evaluate the help the government will give to either higher education or direct help to the students themselves. We feel that since the government has committed itself to the Medicare Program and due to the costs of medical education the government will be required to be of further assistance in training of doctors and nurses.

Saturday evening and Sunday morning were devoted to interviewing applicants for scholarship funds. At the conclusion of interviewing 12 applicants the awards were made to: Dewey F. Bensenhaver of Rig and Deleno H. Webb of St. Marys. We feel that they will be very worthy applicants and they indeed made a very favorable impression on the Committee.

A brief recap of our financial condition is as follows: we have approximately $30,000 in our fund and the expenditures of $8,000.00 which is required for school is covered by dues, gifts and interest on the invested principal.

Respectfully submitted,

J. P. McMullen, M. D.
Chairman.

Wellsburg,
June 23, 1967.

WVU Medical Center
—News—

• **Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.**

Some additions to the faculty of the School of Medicine have been announced by Dr. Harry B. Heflin, Acting President of WVU.

Dr. George H. Khoury, a pediatric cardiologist, joined the Department of Pediatrics on May 15 with the rank of Assistant Professor.

Doctor Khoury completed his pre-medical and medical studies at Cairo University, receiving his M. D. degree in 1955. He came to the United States in 1958, served an internship in Newport News, Virginia, and completed a pediatric residency at the Medical College of Virginia and at Children's Hospital in Denver, Colorado.

He is certified by the American Board of Pediatrics and the Subspecialty Board of Pediatric Cardiology. Before joining the WVU faculty, Doctor Khoury was associated with the Cardiac Diagnostic Service at Children's Hospital in Denver.

Dr. John A. Thomas joined the WVU faculty on May 1 as Associate Professor of Pharmacology.

Doctor Thomas received a B. S. degree in 1956 from Wisconsin State University. He later received master's and Ph.D. degrees from the State University of Iowa. Prior to his recent appointment, he was Associate Professor of Pharmacology at The Creighton University School of Medicine in Omaha, Nebraska.

Dr. Joseph J. McPhillips was named Assistant Professor of Pharmacology, effective July 1.

The author of several scientific articles, Doctor McPhillips held similar academic rank at the Medical College of Virginia before transferring to WVU. He is an alumnus of St. Joseph's College and received his master's and Ph.D degrees at Jefferson Medical College in Philadelphia.

He is a member of the New York and Virginia Academies of Science and the American Association for the Advancement of Science.

Dr. Carlin A. Pinkstaff has joined the Department of Anatomy as an Assistant Professor after teaching at the University of Oregon Dental School.

A graduate of Eastern Illinois University, Doctor Pinkstaff received his Ph.D. from Emory University. He is the author of several scientific articles and abstracts.

Dr. Isaiah A. Wiles has been appointed Clinical Assistant Professor in the Division of Public Health and Preventive Medicine. Doctor Wiles is serving as Health Director and Coroner in Monongalia County.

A native of Tunnelton, Doctor Wiles is an alumnus of Rush Medical School of the University of Chicago and WVU. He was Post Surgeon and Hospital Commander at General Leonard Wood Army Hospital in Missouri before his recent retirement after more than 25 years of service as an Army medical officer.

Van Liere Award Winner

Joel C. Gaydos, a third-year medical student from McClellandtown, Pennsylvania, has received the 1967 Edward J. Van Liere Award.

The award, consisting of an engraved medal and a cash grant of $100, is given annually to the medical student who presents the best paper on original research. It was established in 1965 in honor of Doctor Van Liere, Dean Emeritus and Emeritus Professor of Physiology in the School of Medicine.

Gaydos' research was on "Pyruvate Kinase Deficiency in the Amish."

Doctor Andrews Is Elected

Dr. Charles E. Andrews, Professor of Medicine, has been elected Chief of the Medical and Dental Staff at WVU Hospital.

Elected Assistant Chief of Staff was Dr. Herbert E. Warden, Professor of Surgery. Dr. Rex B. Conn, Associate Professor of Pathology and Director of Clinical Laboratories at the hospital, was elected Secretary.

Doctor Van Liere To Be Honored

Dr. Edward J. Van Liere, Dean Emeritus of the School of Medicine, will be honored during the Centennial Meeting of the West Virginia State Medical Association, which will be held at The Greenbrier in White Sulphur Springs, August 24-26.

There will be a "Van Liere - University Day Program" on Saturday morning, August 26. Seven medical school deans will participate in a discussion of "Medical Education—Past, Current and Future."

Dr. Clark K. Sleeth, who succeeded Doctor Van Liere as Dean, will serve as moderator. Other participants will include:

Dr. William A. Sodeman, Dean Emeritus, Jefferson Medical College, Philadelphia; Dr. William S. Stone, Dean, University of Maryland School of Medicine, Baltimore; Dr. John Parks, Dean, George Washington University School of Medicine, Washington; Dr. Kinloch Nelson, Dean, Medical College of Virginia, Richmond; Dr. Charles A. Doan, Dean Emeritus, Ohio State University School of Medicine, Columbus; and Dr. Kenneth R. Crispell, Dean, University of Virginia School of Medicine, Charlottesville.

After the picnic even Gramps Was a victim of intestinal cramps

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In elderly patients it is particularly important to stop the diarrhea fast. Parepectolin helps you control diarrhea promptly and gain the patient's confidence until etiology has been determined.

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The Month in Washington

JOHN W. Gardner, Secretary of Health, Education and Welfare, called on the medical profession and others in the health field to "search for new and less expensive ways of doing things."

This was the main theme of his talk at the wind-up session of a two-day National Conference on Medical Costs attended by 300 physicians, hospital administrators and other leaders in the various aspects of health care. He said the conference discussions "reflected a universal recognition that change is necessary."

"We cannot go on as we have in the past," Mr. Gardner said. "New patterns will be necessary. Those who entertain some apprehension as to what the new patterns will be had better plunge in and experiment with their own preferred solutions . . . Standing back and condemning the solutions that others devise won't stem the tide of change . . .

". . . there is not yet any agreement as to what a more perfect system would look like. It seems likely that we will go through a period of experimentation and in true American fashion may end up with several variations in different parts of the country, suiting local preferences and conditions.

"Whether the health care system or the future should develop around the hospital as an organizational focus, or around the payment mechanism, or around group practice plans, or around all of these in some sort of collaboration with State health planning councils—or whether other variants will emerge—is still a wide-open question . . .

"Essentially . . . the challenge is before the health profession. They must join the search for solutions. They must be willing to re-examine and overhaul long-established practices. The search for new and better and less expensive ways of doing things must be carried on by hospitals, medical schools, community agencies, and by the thousands of individuals serving the health needs of people . . ."

Doctor Rouse Pledges Support

Dr. Milford O. Rouse, President of the AMA, commended the Administration "for showing its concern for rising health care costs by calling a national conference on the problem.

"The American Medical Association and its member physicians pledge to accept their responsibilities in finding solutions to this vital problem," he said. "We expect that other full members of the health team—dentists, hospitals, nurses, pharmacists and pharmaceutical companies, the insurance industry and others—will do likewise.

• **From the Washington Office of the American Medical Association.**

"We hope the Administration will also accept its responsibility to find ways to ease the burden of inflation which contributes substantially to inflating the cost of medical care. We hope the Administration will call a moratorium on new health legislation until existing programs can be critically evaluated to eliminate overlapping and duplication and to achieve maximum conservation of tax funds. We hope available tax money, particularly in the health field, can be used to help those who really need help while allowing our more fortunate citizens to accept responsibility for their own care."

Community Health Centers

Congress passed and President Johnson signed into law a bill that extends the program of grants for the construction of community health centers for three years (until June 30, 1970).

It authorizes the appropriations of $50 million for fiscal year 1968 and $70 million for 1970.

The amended law also extends the program of grants for the initial staffing of community mental health centers for an additional two years (until 1970) and authorizes the appropriation of $26 million for fiscal 1969 and $32 million for fiscal 1970. An appropriation of $30 million already was authorized for fiscal 1968.

Military Physician Pay Bill

President Johnson signed into law legislation extending the draft for four years. It includes a provision continuing special pay for physicians and dentists.

The new law also continues the authority to defer medical students until completion of internship. In the future, foreign physicians in this country will be liable to draft up to age 35—the same as for Americans. Under the old law, foreign physicians were exempt from age 26.

The present blanket military exemption for Public Health Service officers serving on loan to other agencies such as Food and Drug Administration was removed despite protests by the agencies involved. Such assignments with draft exemption can now be made only to the Coast Guard, Bureau of Prisons and Environmental Services Administration. The American Medical Association had asked Congress to allow no draft exemptions for non-military service.

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Pierce D. Nelson, M. D.

Obituaries

T. E. CATO, M. D.

Dr. T. E. Cato, former public health physician in West Virginia, died in July in Miami, Florida, where he made his home. He was 63.

Doctor Cato was an official of the Dade County, Florida, Health Department.

Many years ago, he served as Director of the Kanawha-Charleston Health Department and the Hancock County Health Department in West Virginia. He left the State in 1940.

A native of Rome, Tennessee, Doctor Cato attended Vanderbilt University and received his M.D. degree in 1928 from the University of Tennessee College of Medicine.

He was a former member of the Hancock and Kanawha Medical Societies and the West Virginia State Medical Association.

Survivors include the widow.

* * * *

JESSE T. JOHNSON, M. D.

Dr. Jesse T. Johnson of Hinton died in a Beckley Hospital on July 8, four days after being injured in an Independence Day traffic accident. He was 67.

Doctor Johnson received his M. D. degree in 1927 from Emory University School of Medicine in Atlanta, Georgia.

He was a member of the Summers County Medical Society, the West Virginia State Medical Association and the American Medical Association.

A native of Henry County, Virginia, Doctor Johnson practiced at the communities of Glade and Meadow Creek before opening his office in Hinton, where he was located for 22 years. He was a former member of the Summers County Board of Education.

Survivors include the widow, Mrs. Della Johnson; three sons, J. T., Jr., of Hinton, Jimmie, stationed with the U. S. Army in Washington, D. C., and William of Germantown, Maryland; a daughter, Mrs. Jennie Lee Moomau of Rickville, Maryland; three brothers, A. E. of Jacksonville, Florida, J. D. of Atlanta, Georgia, and Virgil of Meadow Bridge; two sisters, Mrs. Bernice Thomas of Atlanta and Mrs. Myrtle Hall of Meadow Bridge; and six grandchildren.

* * * *

MILTON JUDSON LILLY, M. D.

Dr. Milton J. Lilly, who practiced medicine in Mason County for 58 years, died at his home on June 24. He was 88.

A native of Mercer County, Doctor Lilly attended Concord College and received his M. D. degree in 1904 at Maryland Medical College in Baltimore. He in-

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terned at Franklin Square Hospital and had post-graduate training at Philadelphia Polyclinic.

Before beginning his practice in Mason County, Doctor Lilly practiced for a time at Switchback in McDowell County.

Survivors include a son, Dr. Milton J. Lilly, Jr., of Charleston; six daughters; two half-brothers; and two half-sisters.

* * * *

C. GLEN McCOY, M. D.

Dr. C. Glen McCoy of Holly Hills, Florida, died in a hospital in Daytona Beach, Florida, on June 15 at the age of 72.

Doctor McCoy was a native of Marion County. He attended West Virginia Wesleyan College and received his M. D. degree in 1922 from the University of Maryland Medical School. He had graduate training at Mercy Hospital in Baltimore before beginning practice in Elm Grove in 1924.

He retired in 1957.

He was an honorary member of the Ohio County Medical Society, of which he was a Past President; the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Rosella Dorsch McCoy; one son, C. Glen McCoy, Jr.; a stepdaughter, Mrs. Kitty Savarino of Naperville, Illinois; and two grandchildren.

* * * *

CLARENCE H. PLYMALE, M. D.

Dr. Clarence H. Plymale of Lighthouse Point, Florida, formerly of Huntington, died on June 26 in a hospital in Dayton, Ohio, where he was a surgical patient. He was 58.

A native of Wayne County, Doctor Plymale attended Marshall and West Virginia Universities before receiving his M. D. degree in 1934 from the University of Louisville School of Medicine. He practiced medicine in Huntington from 1935 until his retirement in 1963, when he moved to Florida.

Doctor Plymale was a former member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Marjorie Miller Plymale; a son, Thomas Lee Plymale of Pompano Beach, Florida; two brothers, Cedric H. Plymale of Fort Lauderdale, Florida, and J. Fred Plymale of Huntington; and three sisters, Mrs. Lena Meier of Boyds, Maryland, and Mrs. Maude Barber and Mrs. Louise Musselman, both of Huntington.

* * * *

EDWARD GEORGE STUART, M. D.

Dr. Edward G. Stuart of Morgantown, Vice President of West Virginia University for the Medical Center, died in University Hospital on June 22 at the age of 47.

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A native of Philadelphia, Doctor Stuart joined WVU in 1960 and served as Associate Professor of Pathology and Associate Dean of the School of Medicine before his appointment to the vice presidency on February 5, 1966. At the time of his death, he also was Director of the University Institute of Biological Sciences.

After five years of service in the Army during World War II, Doctor Stuart received a B. S. degree from West Chester State Teachers College in Pennsylvania in 1948. In 1949, he received a master's degree in zoology at Temple University and, two years later, a Ph.D degree in anatomy at the University of Pennsylvania.

Doctor Stuart received an M. D. degree in 1955 from Duke University School of Medicine, and then he began a career in medical education that sent him to faculty appointments at the University of Virginia, Temple, Duke, Drexel Institute in Philadelphia, and finally to WVU.

Survivors include the widow; 22-year-old twin sons; one sister; and one brother.

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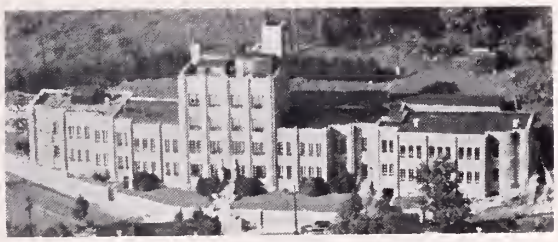

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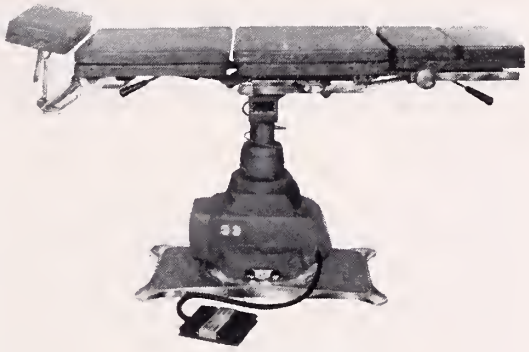

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County Societies

MARION

Dr. Jack C. Morgan of Fairmont was elected President of the Marion County Medical Society at a meeting which was held in June. He succeeds Dr. David Bressler.

Other officers who will serve with Doctor Morgan during the coming year are Dr. Delbert C. Smith, Vice President; Dr. G. Thomas Evans, Secretary; and Dr. R. R. Frye, Treasurer.

* * * *

MONONGALIA

Three members of the House Staff of West Virginia University Hospital presented the scientific program at the regular monthly meeting of the Monongalia County Medical Society which was held in Morgantown on June 6.

Presenting papers were Drs. Lowell T. Mouser, Jorge Cueto and J. Pushkin. Doctor Cueto's paper, "Studies of Experimental Alcoholic Pancreatitis in the Dog," was awarded first place.

It was announced that the Society will conduct measles vaccination clinics the last two Sundays in July, with the Monongalia and State Health Departments providing assistance.—Robert Greco, M. D., Secretary.

* * * *

PRESTON

The Preston County Medical Society conducted a scientific session and all-day outing in June at the Preston Country Club.

Dr. Donald F. Huelke, Associate Professor of Anatomy at the University of Michigan, was the guest speaker.

About 40 members, wives and guests attended the meeting.

* * * *

RALEIGH

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, was guest speaker at the regular monthly meeting of the Raleigh County Medical Society, which was held on June 15 at Henry's Restaurant in Beckley.

During his brief remarks, Doctor Flood outlined the program for this month's 100th Annual Meeting of the State Medical Association, discussed the concept of usual and customary fees for service, and urged physicians to support AMPAC-WESPAC.

The Society admitted to membership Dr. James A. Gardner as a transfer from the Logan County Medical Society.

Thirty-nine members and guests attended the meeting.—Forest A. Cornwell, M. D., Secretary.

Correspondence

SOBISCA S. HALL, M. D.
6th Floor, Empire Bank Building
Clarksburg, W. Va.

George F. Evans, M. D., Editor
The West Virginia Medical Journal
Clarksburg, W. Va.

Dear George:

If my memory is correct, I have never seen a detailed report of the Scholarship Fund of the West Virginia State Medical Association—the monies collected, the monies spent, the number of medical students aided and most important, the final outcome of these students aided. This I think is very important information for the entire membership of the State Medical Association.

In a recent review of our Scholarship Fund of the Harrison County Medical Society, I find that our $12,000.00 has provided a loan fund of $120,000.00 available for our granting of loans through our chosen agency. Comparable figures which I have obtained, shows we may have aided as many as fourteen medical students to the extent of $1000.00 each year for four years or for a probable gift to these fourteen men of a total of $56,000.00. By comparison with the Harrison County Medical Society's Loan Fund, we would now have available on the basis of $56,000.00 given away, a $560,000.00 Loan Fund at the State Medical Association level. It occurs to me that these facts should be made known to the membership at large as they might want to review the possibility of loaning the money instead of giving it away. The Loan Fund of course would be selfperpetuating and would continue to grow over the years and would eventually reach a rather tidy sum from which loans could be made to needy, deserving, applicants indefinitely.

Sincerely yours,

/s/ Sobisca S. Hall, M. D.

SSH:S

West Virginia Pharmacists Hear Doctor Flood

Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association, was a guest speaker at the annual convention of the West Virginia Pharmaceutical Association at The Greenbrier in White Sulphur Springs on July 17.

Doctor Flood proposed an alliance of the health care professions as a means of combatting government intrusions in the health field. He said such an alliance might be organized by medicine, dentistry, osteopathy, pharmacy, nursing and medical technology.

He said all groups should expend 100 per cent effort in receiving their usual and customary fees from patients under government medical programs.

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This endeavor has been warmly endorsed by the American Nurses Association and other professional organizations. We feel sure that such a program, bringing skilled nursing care to the bedside of the cancer patient, will be enthusiastically received by the medical profession.

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About 3,000 family doctors are expected to attend the 19th Annual Scientific Assembly of the American Academy of General Practice, which will be held in Dallas, Texas, September 18-21.

The four-day meeting will feature 26 top speakers on such topics as estrogenic "cycling" of the after-40 woman, the young cardiac, maternal substitutes for the "unmothered child" of the working mother, medicine in the Mekong Delta, and sexual aberrations.

More than 100 scientific exhibits will be on display in Market Hall.

The scientific program will follow the Annual Meeting of the AAGP's policy-making Congress of Delegates, September 16-18. Drs. Seigle W. Parks and Carl B. Hall, both of Charleston, will represent the West Virginia AAGP Chapter in the Congress of Delegates.

Attendance at the Assembly lecture program offers 14 hours of approved postgraduate credit to Academy members.

Additional information about the program may be obtained by writing to the American Academy of General Practice, Volker Boulevard at Brookside, Kansas City, Missouri 64112.

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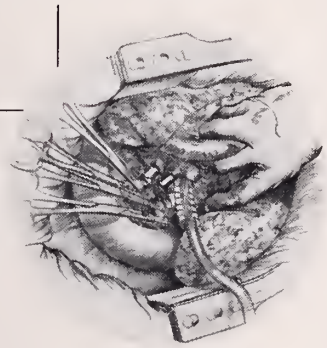

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Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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SEPTEMBER
1967

Vol. 63 No. 9

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston, W. Va. 25324

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50c per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

Member 1967

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The West Virginia Medical Journal

Vol. 63, No. 9 September, 1967

Pulmonary Embolism*

George H. Yeager, M. D., and Jorge O. Just-Viera, M. D.

New diagnostic techniques, such as pulmonary angiography, radioisotope lung scanning, and lactic acid dehydrogenase isozyme determinations have facilitated the diagnosis and study of pulmonary embolism. Experimental and clinical evidence suggests that with time, pulmonary vessels obstructed by emboli may recanalize with restitution of a lumen. In some patients, death occurs before recanalization develops; in others, the embolized vessels remain occluded. Review of some of our experience in this field seemed worthwhile in order to establish some guidelines useful in determining the treatment indicated for patients with different degrees of this condition.

Material.—University of Maryland Hospital records of patients admitted from 1949 to 1963 suspected of having at least one embolic episode were reviewed. One hundred three patients had positive clinical evidence of pulmonary embolism and were included in the study.

Results.—From these patients we evolved a composite picture of pulmonary embolism as it affects the population in our area. The incidence of thrombo-embolism increased with aging, being highest in the sixth decade. This finding is similar to that previously reported in the literature. Noteworthy, in this age group, pulmonary embolism may be masked by diverse illnesses, many of which present with pulmonary problems. Approximately one-fifth of the 103 patients had phlebitis, and slightly more than one-third had cardiovascular disease. Five patients died of thrombo-embolism resulting from trauma (Figure 1).

Approximately one-half of the patients had an embolic episode *after* admission to the hospital (Figure 2). It was impossible to determine from the hospital records the degree of physical activity in those patients who had pulmonary embolism later in their hospital stay. All patients with recognized or suspected pulmonary embolism, however, before entering the hospital

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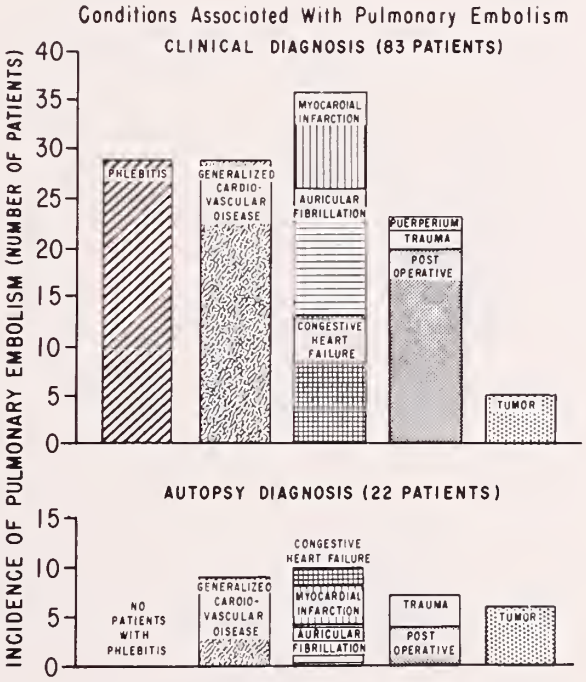

Figure 1

Conditions frequently associated with pulmonary embolism are shown. Examination of the legs for phlebitis is not a routine autopsy procedure. Affections of the cardiovascular system have the highest risk of a thrombo-embolic complication.

*Presented by Doctor Yeager before the 11th Annual Potomac-Shenandoah Valley Postgraduate Institute in Martinsburg, West Virginia, October 28-30, 1966.

gave presenting symptoms suggesting this condition which precipitated their admission. It is believed that in these patients the stage was set for embolism while they were presumably ambulatory and active. This distribution of occurrence reminds the clinician that pulmonary embolism can strike without warning symptoms *even in persons supposedly well.*

Of the 103 patients included in the study, 44 died, of which 22 came to autopsy. It is difficult to evaluate the role of pulmonary embolism in these deaths, but the high mortality certainly remains impressive. Of the patients who died, approximately two-thirds did so within 48 hours of the embolic event (Table I).

Roentgen examination of the chest revealed evidence of "pneumonia" in approximately one-third of patients receiving this examination, whereas it was normal in one-fifth. This again points out that pulmonary embolism may not be associated with or produce radiographically identifiable changes. Similarly, whenever an electrocardiogram was obtained, the diagnostic changes supposedly present in pulmonary embolism were not seen.

During the past few years, massive pulmonary embolism has been simulated in our laboratory by the injection of radiopaque clots. A standard

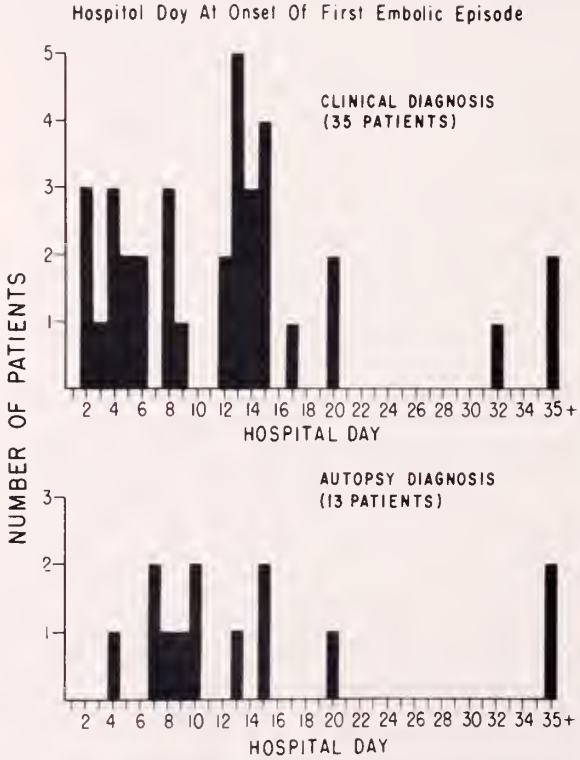

Figure 2

Time of onset after hospitalization of first embolic episode. Most episodes occurred during the first three weeks after admission.

	Time of Death After Onset of Symptoms	Within 15 min.	Within 2 hrs.	Within 12 hrs.	Within 24 hrs.	Within 48 hrs.
Clinical Diagnosis	Number of Patients	3	8	12	14	15
	Percent of Patients	20	53	75	93	100
Autopsy Diagnosis	Number of Patients	3	7	9	11	14
	Percent of Patients	21	50	64	79	100

Table I

Time of death after onset of symptoms following pulmonary embolism in those patients dying within 48 hours after the embolic episode.

experimental preparation was developed and it has been possible to correlate the dose of clot injected with lethality. During the course of these experiments lethality was associated with (1) prompt decrease in arterial blood pressure to levels lower than one-half baseline, (2) cyanosis, with an arterial oxygen desaturation of less than 70 per cent and (3) electrocardiographic changes suggestive of myocardial ischemia. During the review of the hospital records of patients with pulmonary embolism an attempt was made to determine whether or not pulmonary embolism in humans was characterized by changes similar to those observed experimentally.

Of the 103 patients treated for pulmonary embolism, pleuritic pain occurred in 11 per cent, dyspnea in 38 per cent, hemoptysis in 16 per cent and nonpleuritic pain in 35 per cent. These signs and symptoms could not be correlated with an eventual fatal outcome. There also was a group of patients who died so suddenly that they presented none of these manifestations. This segment of the population evidenced shock or cyanosis, or both, most often cyanosis.

When the appearance either of shock or cyanosis was correlated with lethality, however, an interesting relationship was noted. For example, of the 22 patients who came to autopsy and who were proven to have pulmonary embolism, approximately 95 per cent were in shock before death, whereas cyanosis developed in 73 per cent, demonstrating the frequent association of these two conditions with death. Of this group, 11 patients were considered to have died predominantly as a result of embolism.

Discussion.—Pulmonary embolectomy is truly a 20th Century operation. Although many isolated heroic successful applications of the Trendelenberg operation are recorded in the European literature, pulmonary embolectomy has fulfilled its promise in a truly significant number of patients only since the use of cardiopulmonary bypass was applied to this condition at the beginning of the present decade. The initial triumphant reports of removal of multiple large clots from moribund patients, with subsequent

survival, made remarkable presentations at medical meetings. Presently, controversy is growing as to the precise indications for this procedure. As mentioned previously, it is known that in some instances the emboli will recanalize and disappear from the circulation. Some observers have advised against early unilateral embolectomy since patients under 50 years of age rarely, if ever, die from the obstruction of a single major branch of the pulmonary artery.

Study Reveals High Mortality Rate

In our study, the combination of shock, cyanosis and pulmonary embolism was associated with a very high mortality rate. Massive experimental embolism produces shock associated with an altered metabolism evidenced by hyperacidity, anoxemia, hypercarbia and lactic acid accumulation. The combination of these factors has proved lethal. The appearance of shock and cyanosis at any time during the clinical course of a patient afflicted with pulmonary embolism should suggest a grave prognosis. From the available evidence, it does not seem reasonable to pursue a conservative approach if, following adequate diagnosis and documentation of thrombo-embolism, shock or cyanosis appears. In addition, available experimental data substantiate the inefficacy of administration of drugs since neither vasopressors, nor atropine nor papaverine alters the mortality from pulmonary embolism.

At present a reasonable approach to pulmonary embolism would be (1) long-term anticoagulation from embolic episodes involving small emboli. Inferior vena cava procedures should be considered early for recurrent emboli. Patients with a previous history of thrombosis or thrombo-embolism should have aggressive prophylaxis preoperatively and postoperatively. (2) Patients with suspected pulmonary embolism should have pertinent diagnostic studies to define the extent of the condition. These include radio-isotope pulmonary scanning, enzyme determinations with isozyme fractions and pulmonary angiography. These procedures should be performed as early as feasible after the episode, especially if there is strong clinical suspicion of embolism and if not contraindicated by other conditions. (3) Patients with proven diagnosis of pulmonary embolism should be under close surveillance.

The If and When of Pulmonary Embolectomy

Surgical intervention in the improving and asymptomatic patient is debatable. If, however, shock, cyanosis or anginal type of pain has occurred at any time during the patient's hospital course, strong consideration should be given to pulmonary embolectomy, especially when the patient maintains a compensated cardiopulmonary physiology consistent with survival. As noted, a high percentage of these patients eventually will succumb if untreated, due either to the original massive embolus, the metabolic deterioration, or from additional emboli reaching the pulmonary circulation. If blood gas studies and hemodynamic pressure determinations confirm an inadequate tissue perfusion, there is strong experimental and clinical evidence to indicate that in such a situation the burden of proof and greatest responsibility of the eventual outcome lie on those advising conservative and expectant therapy.

Prophylaxis probably is the most important factor in thrombo-embolism. It has been shown that elastic stockings do increase the velocity of blood in the veins of the lower limbs. Stasis also can be prevented in the legs by elevating the foot of the bed 10 to 15 degrees. Patients that are immobilized in bed for prolonged periods of time should have the benefit of physiotherapy since exercising the calf muscles appears to be a most important aid for venous return from the legs.

The Postoperative Period

During the early postoperative period, if the patient's cardiovascular hemodynamics permit, clinical dextran should be given those patients with high risk of embolic complication. Early ambulation remains an extremely important postoperative consideration. Prophylactic early anticoagulation should be considered especially in those patients with a previous episode of venous thrombosis or pulmonary embolism, and who are faced with prolonged bed rest or surgery. In these patients anticoagulants can be started on the third postoperative day and even earlier. Although the matter remains controversial, venous interruption should be limited probably to partial interruption of the inferior vena cava instead of total occlusion, except when septic or very small emboli are involved.

Although an occasional patient will be saved by a properly executed and planned pulmonary embolectomy, there is no doubt that the vast majority of patients will benefit from a prophylactic program defined to prevent or minimize the formation of a readily detachable thrombus.

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Creatine Phosphokinase in Myocardial Infarction*

Jerome C. Arnett, Jr., M. D., Charles E. Ross, M. D., Alphonse C. Edmundowicz, M. D., and Vicente Anido, M. D.

LADUE and associates,[1] in 1954, reported the value of measuring serum activity of glutamic oxaloacetic transaminase during the course of acute myocardial infarction. Over the past decade the importance of this measurement has been confirmed and other enzymes have been proposed, each having properties which might be advantageous in confirming the presence of myocardial necrosis.

All enzymes to date, [2, 3] however, suffer from lack of tissue specificity and consequently lose much of their diagnostic value when myocardial infarction occurs in the presence of, or is complicated by, diseases in which other organs such as the liver or the lungs are involved.

*Supported in part by NIH Grant No. Ro1GM12884, and W. Va. Heart Assn. Grant 66-AG-11N.

Submitted to the Publication Committee, February 16, 1967.

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First Clinical Use in 1959

To achieve more specificity, attention was turned to creatine phosphokinase (CPK), an enzyme involved in transfer of energy-rich phosphate bonds and found abundantly in muscle tissue (Figure 1). Although first described by Lohmann,[4] in 1934, CPK was not used clinically until 1959 in the study of muscle disease.[5] Drey-

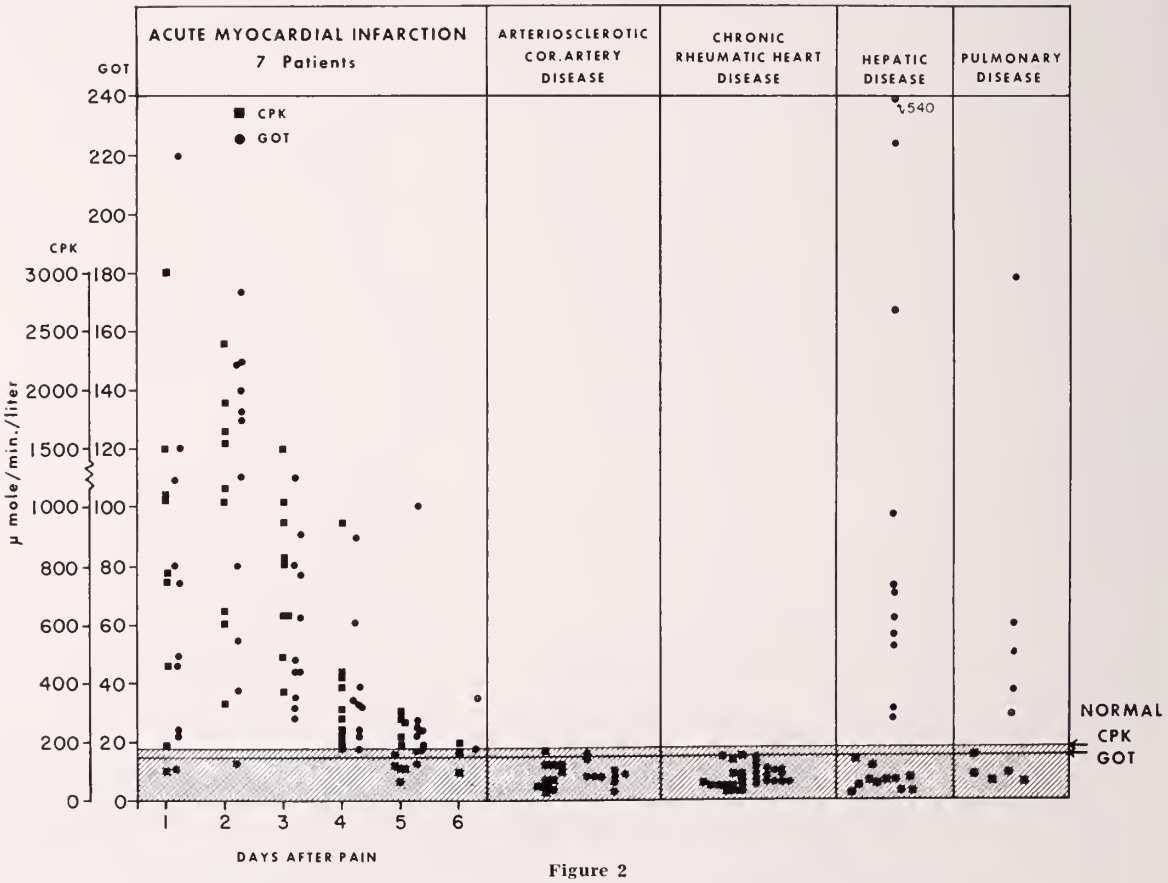

Figure 2

Comparison of CPK and GOT activity in serum of patients with various diseases. In the acute myocardial infarction group, random samples were taken daily over a five to six-day period in seven patients. In the other groups a single blood specimen was taken per patient. Note separation of GOT and CPK in patients with hepatic or pulmonary disease.

$$\text{Creatine} + \text{ATP} \xleftrightarrow{\text{CPK} \quad \text{Mg}^{++}} \text{Creatine Phosphate} + \text{ADP}$$

Figure 1

fus,[6] in 1960, applied serum CPK activity to the diagnosis of myocardial infarction.

Most of the original methods of CPK assay including the popular "Sigma Kit" are spectrophotometric techniques which are prone to insensitivity and unreliability. Conn and Anido[7] recently described a new fluorometric method which is much more sensitive in detecting CPK activity than others to date. Normal values for this method are up to 180 and 110 micro moles/minute/liter for male and female adults, respectively.

A Comparative Study

We compared this fluorometric method with GOT, an established and reliable enzyme in uncomplicated myocardial infarction. The results are shown in Figure 2. In the first column simultaneous CPK and GOT determinations were performed on serum samples obtained from seven patients during the first six days of acute transmural myocardial infarction. Both enzymes revealed strikingly similar activity patterns. Abnormal elevations of serum CPK activity were found as early as eight hours after the onset of chest pain, reached peak levels between the first and second day and returned to normal levels by the fifth and sixth days after chest pain.

In the second column we compared serum enzyme activity in 10 ambulatory patients attending the cardiac clinic. Each had arteriosclerotic coronary artery disease with old myocardial infarction. Five had active angina pectoris (although none were experiencing pain prior to or during sample collection) and all of these patients were in some degree of chronic congestive heart failure. In this group there were no abnormal increases either in CPK or GOT activity. Similar results were found in 15 patients with chronic rheumatic valvular heart disease and various degrees of chronic congestive heart failure. In another group of patients with liver disease, however, there were elevations of serum GOT activity due either to acute hepatitis, alcoholic cirrhosis or metastatic disease. In all of these patients, the serum CPK activity levels were normal.

In another group of five patients with pulmonary disease—three cases of pulmonary infarction and two cases of anaplastic carcinoma of lung—again serum CPK activity was normal while GOT was elevated.

In summary, using the fluorometric method of Conn and Anido for CPK determination, both serum CPK and GOT activities were found to follow similar patterns in patients with acute transmural myocardial infarction. On the basis of this study, CPK appears to be as useful as GOT in uncomplicated myocardial infarction. In patients with myocardial infarction complicated by liver or pulmonary disease, creatine phosphokinase is more organ specific and therefore may be more useful than GOT in differentiating these conditions.

References

1. LaDue, J. S., Wroblewski, F., & Karmen, A.: Serum Glutamic Oxaloacetic Transaminase Activity in Human Acute Transmural Myocardial Infarction, Science 120:497-499, 1954.
2. West, M., Eshchar, J., & Zimmerman, H. J.: Serum Enzymology in the Diagnosis of Myocardial Infarction and Related Cardiovascular Conditions, Med. Clin. North America 50:171-191, (Jan.) 1966.
3. Cohen, L., Djordjevich, J., & Jacobsen, J.: The Contribution of Isozymes of Serum Lactic Dehydrogenase (LDH) to the Diagnosis of Specific Organ Injury, Med. Clin. North America 50:193-209, (Jan.) 1966.
4. Lohmann, K.: Uber die enzymatische Aufspaltung der Kreatinphosphorsaure; zugleich ein Beitrag zum Chemismus der Muskelkontraktion, Biochem. Ztschr. 271:264-277, 1934.
5. Ebashi, S., Toyokura, Y., Momoi, H., & Sugita, H.: High Creatine Phosphokinase Activity of Sera of Progressive Muscular Dystrophy Patients, J. Biochem. (Tokyo) 46:103-104, 1959.
6. Dreyfus, J-C, Schapira, G., Resnais, J., & Scebat, L.: La creatine-phosphokinase dans le diagnostic de L'infarctus du myocarde, Rev. Franc. Etudes Clin. Biol. 5:386-387, 1960.
7. Conn., R. J., & Anido, V.: Creatine Phosphokinase Determination by the Fluorescent Ninhydrin Reaction, Am. J. Clin. Path. 46:177-184, 1966.

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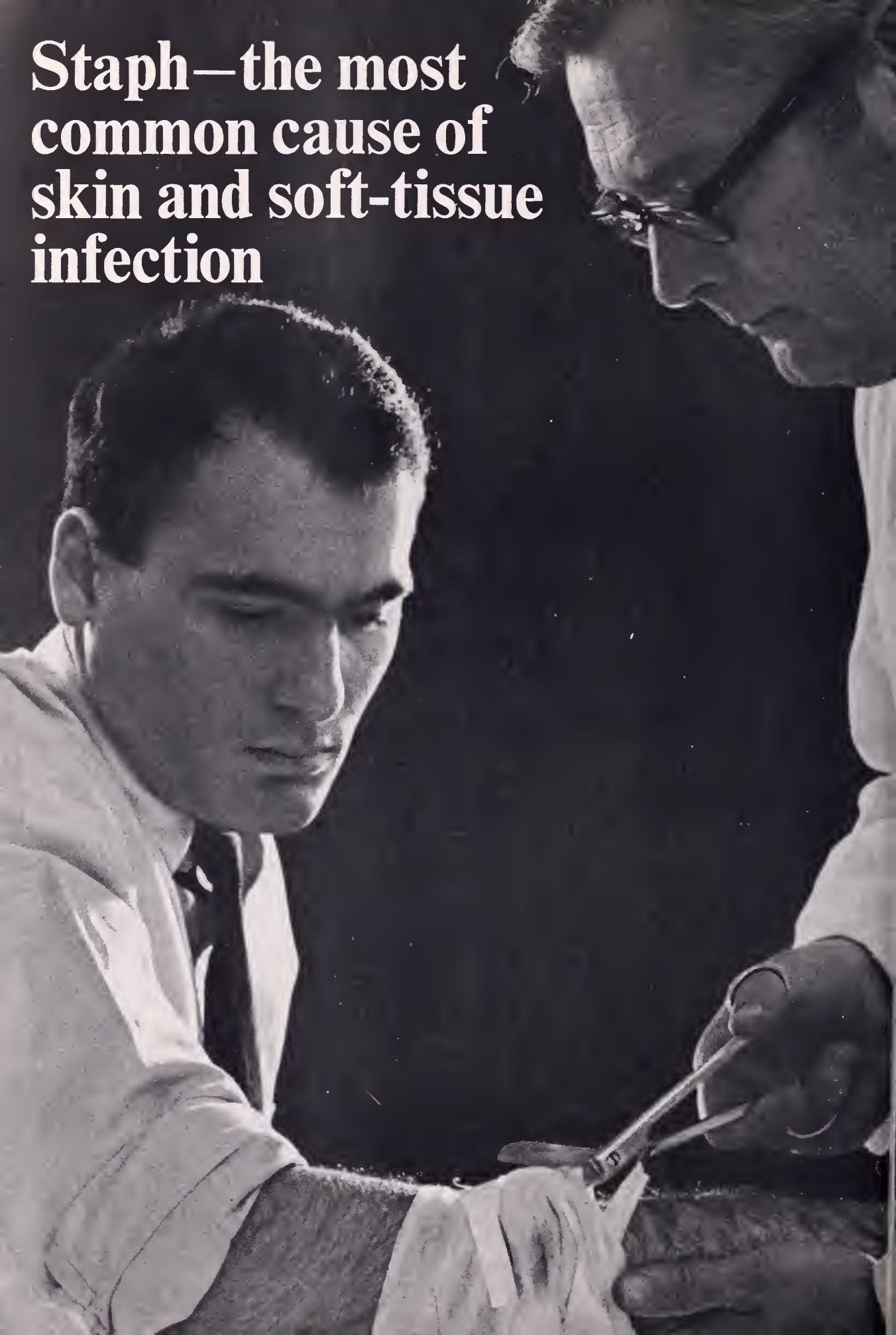

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References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965*, reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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Health Facility Utilization by People Living in West Virginia Hollows

Roger E. Flora, Ph.D., Marilyn A. Jarvis, M. D., and Ernest W. Chick, M. D.

Synopsis-Abstract

Six semi-isolated, rural, non-farm communities were selected for a comprehensive health survey including household interviews, physical and dental examinations and laboratory studies. Interesting variations in patterns of health care utilization were found.

Approximately 50 per cent of the people had seen a physician in the past year; surprisingly, there were only minor variations between different income levels and visits to physicians. Very few availed themselves of dental services. Hospitalization was only slightly less than national estimates. Few utilized the services of the local health department and public health nurses.

Preventive Services Slighted

Most of the services received were for symptomatic illnesses or conditions. Little utilization was made of preventive services or periodic examinations. Information gained from this type of survey should provide insight for long-range planning for adequate health care.

Utilization of health facilities is everyone's concern. The patient, the professional man, the planner, the taxpayer, and the community all have need for this information.

Utilization of health facilities is affected by many factors in West Virginia. Ruggedness of the mountainous terrain, shortage of manpower, lack of public funds, unawareness of the value of preventive medicine, among others, all may affect utilization of health facilities.

The larger population centers of the state offer the citizen many choices in selecting the family physician and dentist. Modern, well equipped hospitals provide emergency care and diagnostic procedures, and contain excellent treatment facilities. Paved roads and public transportation provide ready access to the professional office, the health department clinic, or the hospital.

The Rural Areas

One-half of the population of West Virginia, however, is in rural areas, with their communities of houses dotted along ridges or scattered up hollows. Winding dirt roads, following the creek between two mountain slopes, connect these homes to the highway, if cars are available. Oftentimes there still is a considerable distance by highway to medical facilities.

Submitted to the Publication Committee, December 27, 1966.

The Authors

- **Roger E. Flora, Ph.D., Marilyn A. Jarvis, M. D., and Ernest W. Chick, M. D., Department of Medicine, Division of Preventive Medicine and Public Health, West Virginia University School of Medicine, Morgantown.**

How well do these people, often hampered by lack of information and money, utilize medical facilities? An answer to this question was obtained during recent medicodental surveys in six rural, nonfarm communities.

The Communities.—The communities No. 1, No. 2, and No. 3 are rural, non-farm, ridge or hollow communities in three separate counties encircling Kanawha County in Central West Virginia (Table 1). Each has one church building, but only community No. 2 has a post office, grocery stores, a very small local industry, and a public grade school within its borders. The distance to the nearest physician's office is approximately 10 miles for each citizen. Hospitals are 15-30 miles away. Health departments, located in the county seats and each served by one public health nurse, are 10-15 miles away from the communities. The family incomes tend to be low (Table 2). The heads of households are primarily blue-collar workers, with such varied occupations as service station attendant, highway maintenance worker, janitor, carpenter and tire recapper. Although some keep a few chickens and grow a few vegetables, few, if any, would be considered farmers.

Communities No. 4, No. 5 and No. 6 are located within the same southern West Virginia county. The communities encircle the county seat where the majority of health facilities are available including the health department staffed by four public health nurses. Half to three-fourths of an hour is required by each citizen

to reach the county seat. Local practitioners are available within 10 miles of each community. Again the socio-economic level of the citizens tends to be low (Table 2). The occupation largely is mining. The only public buildings within the hollows are churches except in the case of community No. 4 which has two small grocery stores.

The Surveys.—In all six communities each home was visited by medical students who had received special training in interviewing. A questionnaire was completed by interviewing a responsible member of each home. Information was obtained from 268 families consisting of 1,092 persons of all ages, these latter representing over 95 per cent of all families residing in the six communities.

Included were questions concerning length of time in the community, level of income, and sanitation for the household. In addition, for each individual in the household, information was obtained on history of past illnesses, utilization of medical and dental services, and sources of funds for payment for these services. Such information was verified during subsequent physical and dental examinations of over 60 per cent of people interviewed.

The information in this report is a small part of the larger studies jointly undertaken by the West Virginia University Medical Center and the Cooperative Extension Service, West Virginia University Center for Appalachian Studies and Development in communities No. 1, No. 2, and No. 3 and the West Virginia University

TABLE 1

Utilization Of Health Care Opportunities During The Year Preceding Interview By Individuals, All Ages and All Incomes In Six Selected Communities, West Virginia, 1965-1966

Community	No. Of Families	No. Of People	Physician Care	Dental Service	Hospital Overnight	Health Dept. Clinic	County P.H.N. Home Visit	Utilized Voc. Rehab.
1	67	234	142(61%)	48(21%)	32(14%)	17(7%)	7(3%)	5(2%)
2	33	130	67(52%)	18(14%)	13(10%)	4(3%)	0	3(2%)
3	36	152	65(43%)	24(16%)	12(8%)	14(10%)	6(4%)	0
4	34	199	91(46%)	33(17%)	17(9%)	34(17%)	12(6%)	3(2%)
5	53	195	80(41%)	17(9%)	28(14%)	17(9%)	0	8(4)%
6	45	182	107(59%)	24(13%)	29(16%)	15(8%)	0	9(5)%

TABLE 2

Utilization Of Health Care Opportunities During The Year Preceding Interview For Individuals of All Ages By Level of Income In Six Selected Communities, West Virginia, 1965-1966

Community	Income Level	No. Of Families*	No. Of People	Physician Care	Dental Service	Hospital Overnight	Health Dept. Clinic	County P.H.N. Home Visit	Voc. Rehab.
	3,000	33	94	62(66%)	15(16%)	12(13%)	5(5%)	2(2%)	0
#1	3,000-6,999	26	111	61(55%)	22(20%)	14(13%)	9(8%)	5(5%)	5(5%)
	7,000+	8	29	19(66%)	11(38%)	6(21%)	3(10%)	0	0
	3,000	12	32	13(41%)	4(13%)	6(19%)	4(13%)	0	3(%9)
#2	3,000-6,999	15	72	38(53%)	12(17%)	6(8%)	0 .	0	0
	7,000+	5	24	15(63%)	2(8%)	1(4%)	0	0	0
	3,000	26	115	50(44%)	14(12%)	9(8%)	14(12%)	6(5%)	...
#3	3,000-6,999	8	28	9(32%)	6(21%)	3(11%)	0	0	...
	7,000+	1	3	3(100%)	3(100%)	0	0	0	...
	3,000	23	142	61(43%)	21(15%)	13(9%)	29(20%)	12(9%)	3(2%)
#4	3,000-6,999	10	52	29(56%)	11(21%)	3(6%)	5(10%)	0	0
	7,000+	0	0	0	0	0	0	0	0
	3,000	26	76	32(42%)	6(8%)	7(9%)	3(4%)	0	0
#5	3,000-6,999	9	36	18(50%)	5(14%)	10(28%)	4(11%)	0	3(8%)
	7,000+	4	16	3(19%)	1(6%)	1(6%)	2(13%)	0	0
	3,000	29	96	62(65%)	10(10%)	18(19%)	2(2%)	0	3(3%)
#6	3,000-6,999	10	61	36(59%)	9(15%)	10(16%)	12(20%)	0	3(5%)
	7,000+	1	3	3(100%)	2(67%)	0	0	0	3(100%)

* Totals will not compare with Table 1 because Table 1 includes families with unknown incomes.

Institute of Human Resources in communities No. 4, No. 5 and No. 6.[1,2]

Utilization of Medical Services.—Information was obtained as to how many individuals in each home within the year preceding interview had (a) received the services of a physician or dentist, (b) been hospitalized overnight, or had utilized the services of (c) the county health department or (d) vocational rehabilitation agencies. An additional tabulation was made for homes visited by a public health nurse and is summarized for each of the six communities in Table 1.

The pattern of utilization is further broken down for comparison with the level of income of the family in Table 2. Sources of funds used in payment for medical services at each income level of the families are summarized in Table 3.

Discussion.—Utilization of professional services and facilities varies among the communities and does not appear related to income levels since these variations are present in each income level of the communities.

For perspective, certain areas of utilization may be compared with the findings of the National Health Survey of the United States Public Health Service which, since 1957, has employed the interview technique to statistically selected samples of households throughout the United States and reports the findings by geographic area and region. Between 1963-1964, the National Health Survey reports that in the southern region of the United States (including West Virginia) an estimated 63.8 per cent of persons in all income and age levels received the services of a physician within one year.[3] The West Virginia "hollow" communities are low in comparison, ranging by community from 41 to 61 per cent of individuals seeing a physician, or over-all approximately 50 per cent.

A comparison of visits to the dentist is startling. In the south, the National Health Survey reports that an individual makes on the average 1.1 visits per year to the dentist.[4] In the West Virginia "hollow" communities, only 8 to 20 per cent of persons made dental visits in the past year. Twenty per cent of the population would have to average 5.5 visits per person to attain an average of 1.1 visits per person per year for the total population. If only 8 per cent of the people made dental visits within a year, an average of 13.8 visits per person would be required to attain the reported 1.1 visits per person per year for the total population. Lack of dental care in these communities is reflected in the

TABLE 3

Source of Payment for Medical Care By Income Levels for Households in Six Selected Communities, West Virginia, 1965-1966

Community	Income Level	No. Of Households	No. Outside Help	Welfare	Medicare	Hospital Insurance Only	Hospital And Physician Insurance	Total With Some Outside Help**
	3,000	33	10(30%)	13(40%)	5(15%)	1(3%)	4(12%)	23(70%)
#1	3,000-6,999	26	3(11%)	0	1	3(12%)	19(73%)	23(88%)
	7,000+	8	1(13%)	0	0	0	7(88%)	7(88%)
	Total	67	14(21%)	13(19%)	6(9%)	4(6%)	30(45%)	53(79%)
	3,000	12	7(58%)	0	3(25%)	0	2(17%)	5(42%)
#2	3,000-6,999	15	5(33%)	0	0	1(7%)	9(60%)	10(67%)
	7,000+	5	1(20%)	0	0	0	4(80%)	4(80%)
	Total*	33	14(42%)	0	3(9%)	1(3%)	15(46%)	19(58%)
	3,000	26	15(58%)	4(15%)	...	4(15%)	3(12%)	11(42%)
#3	3,000-6,999	8	1(13%)	1(13%)	...	2(25%)	4(50%)	7(87%)
	7,000+	1	0	0	...	1(100%)	0	1(100%)
	Total*	36	17(47%)	5(14%)	...	7(19%)	7(19%)	19(53%)
	3,000	23	8(35%)	11(47%)	2(9%)	0	2(9%)	15(65%)
#4	3,000-6,999	10	0	2(20%)	0	2(20%)	6(60%)	10(100%)
	7,000+	0	0	0	0	0	0	0
	Total*	34	9(26%)	13(38%)	2(6%)	2(6%)	8(24%)	25(74%)
	3,000	26	15(58%)	6(23%)	2(8%)	0	3(11%)	11(42%)
#5	3,000-6,999	9	2(22%)	1(11%)	0	0	6(67%)	7(78%)
	7,000+	4	1(25%)	1(25%)	0	1(25%)	1(25%)	3(75%)
	Total*	53	29(55%)	11(21%)	2(3%)	1(2%)	10(19%)	24(45%)
	3,000	29	9(31%)	13(45%)	2(7%)	0	5(17%)	20(69%)
#6	3,000-6,999	10	1(10%)	3(30%)	0	2(20%)	4(40%)	9(90%)
	7,000+	1	0	0	0	0	1(100%)	1(100%)
	Total*	45	12(27%)	19(43%)	2(4%)	2(4%)	10(22%)	33(73%)

* Totals include unknown income lavels.

**Includes welfare, medicare, and all types of medical insurance.

TABLE 4

Hospital Discharge Rate Per Year and Per Cent of Population (All Ages) Seeing a Physician In One Year By Income Derived from The National Health Survey Report*, 1963-1964

	$3,000	$3,000-6,999	$7,000+	All Levels
Per cent of Population with Physician visit In one year	59.5%	65.7%	71.1%	66.1%
Hospital Discharge rate Per 100 persons** Per Year	14.1	13.3	11.9	12.8

* Reference (3)

**Rate per 100 people may be used as per cent if one assumes each hospitalized person was in the hospital only once during the given year.

magnitude of dental diseases and conditions observed.[5]

With regard to hospitalization, however, the West Virginia communities are not too different from the southern region. The National Health Survey indicates the hospital discharge rate per year per 100 people in the south is 13.6.[3] If no person were hospitalized more than once per year, 13.6 per cent of the population in the south would have been hospitalized in that year. The population percentage of persons hospitalized in the West Virginia communities ranged from 8 to 16 per cent or an over-all 10 per cent. It should be pointed out that in four of the six communities the range was 10 to 16 per cent, near the average for the southern region. Reasons for the lower percentage in the remaining two communities are open to speculation.

Obvious lack of utilization of some of these facilities in West Virginia very well may be due to lack of knowledge of their existence for the individual. It may be due to the individual's shyness, fear of unknown procedures, or reluctance to try something new. It may be due to a fatalistic attitude that "what comes, comes," and cannot or should not be prevented or alleviated.

It often is thought that lack of utilization of facilities is due to lack of money to pay for services. Table 2 shows the breakdown of utilization by income levels in an attempt to find a personal economic reason for not visiting a physician or dentist. This may again be contrasted with data from the National Health Survey by referring to Table 4.[3]

Further information as to sources of help for payment of medical-dental fees is revealed in Table 3. Not all persons known to be eligible for welfare subsidy admitted this. Perhaps the respondents did not understand the question, or perhaps they did not realize they were eligible for medical benefits. Data in Table 3 are listed exactly as the respondent answered the question.

Although the National Health Survey has collected statistics concerning hospital and surgical insurance coverage,[5] the data cannot be compared because of different classifications used by the two surveys.

The National Health Survey does not accumulate data concerning health department clinic visits, home care visits, nor the use of vocational rehabilitation services. Therefore, there is no basis for determining if the low percentage of utilization of these services in the West Virginia communities follows a pattern for this region.

* * * *

The following medical students participated in this study: Richard Six, Edward Wheatley, Joseph Schwerha, Richard Castle and John Meadows.

References

1. Jarvis, M. A., Chick, E. W., Six, R., & Wheatley, E.: Health in a Semi-Isolated West Virginia Community, Arch. Environ. Hlth. 13:422-428, (Oct.) 1966.
2. Schwerha, J. J., Chick, E. W., & Jarvis, M. A.: A Unique Learning Experience: Community Health in a Rural Area, *The West Virginia Medical Journal* 63, No. 1, (Jan.) 1967.
3. Vital and Health Statistics, Series 10, No. 32, USPHS, pp. 26-37, (June) 1966.
4. Ibid.: Series 10, No. 23, USPHS, p. 3, (Oct.) 1965.
5. Salerno, F. R., & Oakes, R. E.: Dental Surveys in the Hollows of Appalachia, J. Pub. Hlth. Dent., unpublished data.
6. Vital and Health Statistics, Series 10, No. 11, USPHS (August) 1964.
7. Ibid.: Series 10, No. 16, USPHS (April) 1965.

Short words are best and the old words when short are best of all.

WINSTON CHURCHILL

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Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, acute gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis.

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Precautions: Before prescribing, carefully select patients, avc those responsive to routine measures as well as contraindicate a- tients. Obtain a detailed history and a complete physical and labor ry examination, including a blood count. The patient should not e) ed recommended dosage, should be closely supervised and shou be warned to discontinue the drug and report immediately if fever, re throat, or mouth lesions (symptoms of blood dyscrasia); sudden w gain (water retention); skin reactions; black or tarry stools or er evidence of intestinal hemorrhage occur. Make regular blood cc ts Discontinue the drug immediately and institute countermeasures. he white count changes significantly, granulocytes decrease, or imm re forms appear. Use greater care in the elderly and in hyperten es.

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Special Article

What Society Expects From the Physician*

Dana L. Farnsworth, M. D.

THIRTY-EIGHT years ago, when I began the study of medicine in the little red brick building which used to stand down on University Avenue near where Armstrong Hall now stands, Doctor Van Liere, then Professor of Physiology, greeted us with his comments on medicine as a jealous mistress, a theme with which I have been preoccupied in various ways ever since. To be able to come back and speak to you, and to have Doctor Van Liere in the audience, is pleasure of the highest order; without his example, wise counsel, and encouragement, my life would have been very different. Just where the road not taken would have led me I will never know, but I am glad I paid attention to his suggestions. He embodied and conveyed to his students that dignity which characterizes the practice of medicine at its best, and gave us the example of a man interested in the arts as well as the sciences, in research as well as teaching and practice, in the human being as well as his pathology. Statesmen in medicine have always been needed, but never more than now. I hope that all of you will try to live up to the ideals he has upheld so long and so well.

Americans are now expecting and demanding health care superior to, and more extensively available than, that which they currently receive. These expectations and demands exceed what members of the health professions, using traditional methods, can provide. Personnel shortages exist in practically every health field. We have too few physicians, nurses and technologists of all kinds. It is unlikely that the shortage of physicians and nurses can be corrected within the next decade or two. This means that we must find ways of enlisting the aid of members of the other health professions and occupations if we are to maintain the quality of present-day medical care.

About 11 persons (on the average) now work with every physician for the direct health care of patients. This will increase markedly (probably to 20 to 1 in the next decade) because of the combination of increasing expectations and the impossibility of producing enough physicians to meet health needs (if they work as they have in the past). Not only will physicians have to learn to work with more associates and assistants, but they will of necessity have to put more emphasis on preventive measures. Instead of waiting for people to become ill and come to us for help, we will be expected to pay increasing attention to those factors in society and the environment which predispose them to disease and injury. Our vested interests will shift gradually from the diseases of our patients to the health of our citizens. Obviously this will call for radical shifts in attitudes as well as practices; these changes are now occurring. The medical profession must try to understand and to keep up with social forces set in motion by some of its own members in cooperation with lay groups.

Medicine is being called upon to perform complex tasks involving correcting deficiencies, decreasing pain, and increasing longevity. It is responding magnificently. What it has not done too well is to provide a system that would make medical service readily available to the great majority of people and to place proper emphasis on preventing disease and injury. It may well be that a disproportionate amount of effort is being expended in salvage operations, as compared to the less dramatic task of improving daily life by means of strong programs of health education, control of environmental pollution, and other preventive measures.

The medical profession has been criticized for placing undue emphasis on exceedingly costly procedures for the relatively few who suffer very serious disorders and neglecting the more

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***Presented at the pre-commencement exercises for senior medical students at the West Virginia University School of Medicine in Morgantown, May 13, 1967.**

numerous and simpler measures that would provide proper health care and disease prevention for many more people. I question whether such a choice is in fact necessary. Our system of values is the crucial issue. Investigators tend to work in areas in which the rewards of esteem and prestige, financial return and academic appointments are most readily attained. Why should knowledge about molecules, for example, be worth more than knowledge about a society in which people, not atoms, are the variables?

Dealing With Stress

Given our highly complex society, with all its demands, isn't it absolutely necessary that we devote our time and skills to questions of how people deal with stress, particularly with emotional stress? We know little about the process of symptom formation, the indication that stress is becoming distress. One person becomes anxious, another turns apathetic or depressed, a third "acts out" his feelings, and a fourth uses escape mechanisms. Still others develop disorders of physiological function, and a few lose touch with reality and become psychotic. Interpretation of what has occurred in the past is far more useful than predicting what will happen in the future.

Everyone has serious problems at various times throughout his life. Mental health is not the absence of problems. It is a fundamental state and an orientation manifested in sound approaches to tasks, challenges, difficulties, and dangers. Physicians should learn to recognize early signs that unsound approaches to human problems are being adopted. The more dramatic and tragic of such approaches include resort to personal violence (child beating and other delinquent and criminal behavior) and use of escape measures which impair the individual's usefulness (unauthorized use of harmful drugs, periodic drunkenness). Psychiatric emergencies do not occur spontaneously or "out of the blue." Investigation of the backgrounds of individuals who have become involved in precipitious action almost always reveals a gradual accumulation of emotional conflicts and increase of tension up to the point at which the individual loses control (becomes decompensated).

Lay People Needed as Collaborators

Psychiatrists cannot be expected to pick up the signals warning of potentially unbearable stress because, in most regions of the country, they have little opportunity to see patients until after the latter are far along in their illnesses; however, even if people could be observed early in the course of their difficulties, there are too few psychiatrists in practice for them to carry out such a function—in fact, it would still be impossible if they were joined by physicians of all kinds, although their combined efforts to carry out preventive measures would be very helpful. A variety of lay people are needed as collaborators. The most important of these are teachers, members of the religious, and all others who are members of the caretaking professions and occupations. Their efforts should ultimately be directed toward the support of the family, i.e., encouraging parents in the behavior and activities which foster in children attitudes of responsibility, self-reliance and self-respect.

Little by little, medical practitioners are being forced to face problems that are unpleasant, complex and of diverse causes. Progress in the control of infections and improvement in housing conditions, nutrition and surgical techniques (to name only a few such areas) has surpassed all reasonable expectations of a half-century ago; the more stubborn obstacles to human fulfillment are now emerging. Degenerative and malignant disorders and the ravages of emotional conflict are among our greatest challenges.

'Knowledge Explosion'

The so-called knowledge explosion (and the connotations of violence carried by this term should not be overlooked) is significant for the new physician. It is said that knowledge in all fields is doubling every 10 years. Those of us who were graduated from medical school 25 to 30 years ago are painfully aware of how impossible it is to keep thoroughly up to date even in our chosen medical specialty. Thirty years ago a medical school dean told his entering class that in 20 years half of all they learned in medical school would be incorrect or irrelevant, and added, "But the tragedy is that we don't know which half it is."

The new physician need not master the field of medicine, or even a significant part of it. But he can reasonably expect to learn how to use specialized knowledge with competence, skill, integrity and good judgment. He should be aware of his limitations, familiar with the vocabulary and resources of his chosen field of interest, and devoted to increasing his knowledge via an organized curiosity—that is, by being research-minded. To do this he should not only be a student of his own specialty, but should direct some of his intellectual energy toward relating what he is doing to the rest of medicine and to the needs of society.

The factors impairing a physician's effectiveness often stem from his own personal characteristics. There is no substitute for competence;

however, a physician cannot do his best unless he likes people and genuinely cares for his patients. Patients usually want consideration for themselves as well as for their disorders, but they don't want an ostentatious (and insincere) display of it. James Howard Means once said that what we most need in physician-patient relations is not better bedside manners but better manners at the bedside.

Unfortunately, most of the kinds of behavior which irritate or alienate patients represent a loss of good manners and sensitivity to the patients' point of view. All too often students entering medical school are more aware of how people react to subtle emotional stimuli than they are when they enter practice some five to nine years later. Exposure to the severe stresses of life-and-death responsibilities, the unreasonable demands of a few thoughtless patients, fatigue, and overemphasis on the laboratory aspects of medicine may combine to encourage loss (or denial) of feeling and sensitivity to other people's emotional states.

Treatment of the Patient

Unfortunately, some physicians become so preoccupied with their own problems, fatigue or exasperation with the demands made on them that they are ignorant of the impression they make on their patients. Even in the best-run hospitals physicians occasionally alienate patients by being brusque with them, using sarcasm to show their displeasure, or talking at the bedside as if patients could not hear, see, or understand what was going on around them. Some physicians fail to realize that patients' anxieties often wear a mask of rudeness, hostility or bad manners. Having themselves developed certain defenses, they may forget that illness is a crisis situation in which patients are frightened and vulnerable. Others overgeneralize from their personal experience, overreassure their patients, or do not give them adequate opportunity to express their feelings. Lack of discretion about confidentiality, talking loudly, smoking during an examination, and lack of personal neatness destroy patients' confidence. Sometimes patients are given little instruction about what to do if their symptoms increase or new and unexpected forms of their illness appear.

It is regrettable that these simple precepts must be articulated but in fact it is constantly necessary to re-acquaint ourselves with them. Only by continually training ourselves in self-discipline can we avoid mistakes such as those mentioned. Even then we will occasionally fail to live up to our own standards; but we can always try.

Over the next few decades, radical changes in physicians' attitudes will be necessary. These changes may not seem as radical to you who are just entering practice (whether treatment, research or teaching) as to physicians who have been practicing for several years. You will be more cognizent of the broad reaches of preventive medicine—of how health is affected by economic well-being, good nutrition, good housing and sanitary measures—than your predecessors have been. You will of necessity become concerned with the sociology of community organizations and with means of helping them work together to meet community health needs. You will have to pay more attention to early signs of ill-health and learn to identify practices that will, if continued, lead to distress. You will have to be concerned, both as physicians and citizens, with the by-products of our high material standards of living: air pollution, water pollution and the even more tragic pollution of minds that results from loss of meaning and purpose and impulse expression carried out on the most primitive levels.

The old dichotomies and dualisms are giving way to more comprehensive views of man and society in which the interdependence of all human undertakings and experiences is acknowledged. The "whole man" (and ideally this phrase extends beyond its old meaning and connotes health and productivity) exists in a society which is also subject to disease. Medicine must assume its appropriate leadership role in defining these threats to society and in working for their mitigation.

Think like a man of action and act like a man of thought.

HENRY BERGSON

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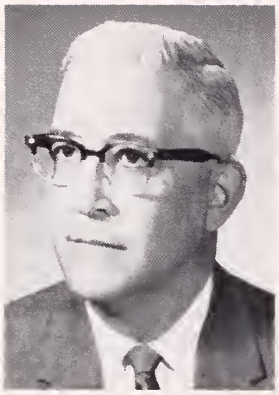
For advanced registration, please complete the following form and mail to: West Virginia State Medical Association, P. O. Box 1031, Charleston, W. Va. 25324.
Checks should be made payable to "West Virginia State Medical Association."

Please register me in the Cardiac Auscultation Review course to be presented at Thomas Memorial Hospital in South Charleston on Sept. 9. My registration fee is (is not) enclosed.

Name (please print) _____ *Specialty* _____

Address _____ *City* _____



A message from . . .

The President

HOW DO WE TALK WITH YOU?

In the past several years, communication of information on economic, social, political and professional matters between the State Medical Association and individual physicians has become increasingly difficult. Many times information which should have reached individual physicians has failed to do so and, as a result, a great deal of time and effort is spent in matters which have already been considered by the Council of the West Virginia State Medical Association.

From this, it is apparent that the actions of the Council are not being brought to the notice of the individual physicians practicing in West Virginia. The reason for this deficiency in communications is not clear. Council minutes are published in *The West Virginia Medical Journal* for all to read. Editorials also are written in *The Journal* concerning problems arising for Council consideration. Still, this is obviously inadequate. Some other means of communication must be developed to present the actions of the Council to the individual practicing physician.

One method of transmitting information is by individual letter to explain and elaborate on the Council meetings. This is the method that I would prefer in sending out additional information. A second method of transmittal of information is the verbal report on the actions of the Council by the councilors from each district to each county medical society. This method, however, does not allow for the failure of members to attend their county medical society meetings or for the failure or inability of the councilor to attend the county medical society meeting. Nevertheless, one of these methods will probably need to be used for the transmittal of information. It is my belief that each individual member of the State Medical Association needs to be furnished with an accurate and complete copy of minutes of the Council and of the House of Delegates of the West Virginia State Medical Association as soon as possible after the meeting.

I also would like to point out that transmittal of information from the individual physician to the State Medical Association is also deficient in quantity. Please send us letters concerning your ideas, problems, suggestions and questions so that we may try to be helpful to you in the future.

Richard V. Lynch, M.D.

Richard V. Lynch, Jr., M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

NOT A DECISION FOR THE IRS

On April 14, 1967, the Internal Revenue Service issued a regulation which would tax the profits from advertising in publications of tax exempt organizations. To a service society like the West Virginia State Medical Association, this regulation could seriously affect *The West Virginia Medical Journal. The Journal* receives most of its advertising through a non-profit agency, The State Medical Journal Advertising Bureau. A very small per cent of its advertising income is derived from local business.

In the past year *The Journal* can show a slight financial profit for the first year in a decade. Income withered away for several years after the Kefauver attack. Until 1967 it did not make a comeback. Now it appears from the activities of the Internal Revenue Service that we shall again be pushed into the red. It is doubtful if *The Journal* can survive this tax onslaught without further deficit.

Sen. Vance Hartke of Indiana, on June 12, 1967, in the United States Senate, attacked this regulation of the Internal Revenue Service, stating that although this income accounts for less than one per cent of the advertising dollar, it permitted "such organizations (Boy Scouts, Girl Scouts, National Geographic Society, National Education Association, American Bar Association, and the American Medical, American Dental Associations) to pursue lofty goals and fill desperately needed places in our American scheme of things."

He stated, "It is for Congress to decide whether new guidelines are needed to determine whether some activities of tax-exempt organizations should be taxed. It is for Congress to determine whether tax regulations governing such organizations should be changed. It is not for the Internal Revenue Service to decide.

"I earnestly believe that the matter should be thoroughly aired by the House Committee on Ways and Means and by the Senate Committee on Finance. I shall myself urge the Chairman of the Finance Committee to examine this situation with the view toward seeking equity and keeping the Internal Revenue Service from writing laws."

Although the regulation of the Internal Revenue Service stems from a 17-year-old law, aimed at the activities of New York University which had gone into the macaroni business, it should not be extended to legitimate non-profit

activities related to the purpose for which the organization was created.

It may be that some action on this matter should be considered, such as a determined protest to our Congressional representatives and an appeal to similar organizations in West Virginia to make their weight felt against this unjust interpretation of a law by the Internal Revenue Service.

HUMOR IN MEDICAL TERMINOLOGY

When writing of humor in medicine one is reminded of the statement made many years ago by Sir Arthur Conan Doyle. He wrote: "You'll find there's so much tragedy in a doctor's life, my boy, that he would not be able to stand it if it were not for the strain of comedy which comes every now and then to leaven it."

It is not often that a new medical syndrome or medical term lends itself to humor; for the main part new terms are dignified and scholarly. Many of them are derived from the Greek or Latin which often result in sesquipedalian words. Occasionally, however, an unusual term is suggested which is succint, euphonious and meaningful. Recently, such a term made its happy appearance, namely "the subclavian steal."

In essence, the subclavian steal syndrome is produced by a localized arterial obstruction, such as may be found in the subclavian artery. If this obtains, there is a fall of pressure in the vertebral artery on the same side, which causes a reversal of blood flow with a siphoning of blood from the opposite vertebral-basilar system. The reversal of blood flow causes a deficiency of blood to certain parts of the brain, which often produces manifold symptoms.

The phenomenon was first described by Contorni[1] and later confirmed and amplified by Reivich et al.[2] *The New England Journal of Medicine* in an editorial[3] introduced the term "subclavian steal," which has been widely adopted.

As might be anticipated a number of imaginative medical writers have offered several variants. It has been suggested, for example, that if the brain is deprived of only a small amount of blood, the condition be called "a subclavian snitch,"[4] but when a large amount of blood is shunted from the brain, it might be designated as "vertebral grand larceny."[5] Other arresting terms, such as "the brain drain" or "the great brain robbery" have also been suggested.[6] No doubt other interesting and provocative terms will soon be forthcoming.

We feel certain that the imaginative authors who have suggested these amusing terms for the subclavian steal syndrome in no way wish to convey the impression of belittling the potential seriousness of the syndrome. This philosophy is also shared by the writer of this editorial. It is refreshing, however, to encounter a term which enlivens and invigorates the medical literature and so helps relieve the stodginess so often found in medical writing.

1. Contorni, L.: Minerva chir. 15:268, 1960.
2. Reivich, M., Holling, H. E., Roberts, B. and Toole, J. F.: New England J. Med. 265:878, 1961.
3. Editorial: A new vascular syndrome—"The subclavian steal." New England J. Med. 265:912, 1961.
4. Heyman, A. Discussion. In Cerebral Vascular Diseases. Transactions of the Fourth Princeton Conference. Eds. R. G. Siekart and J. P. Whisnant. New York. Grune and Stratton, 1965, p. 119.
5. Daves, M. L. and Treger, A.: Circulation 29:911, 1964.
6. Marshall, R. J. and Mantini, E. L.: Circulation 31:249, 1965.

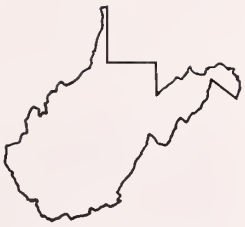
Generic vs. Trade Name Prescriptions

Considerable debate is current regarding the prescribing of drugs by generic or by trade name. Government agencies seem to favor regulatory legislation requiring generic name on all prescriptions. Manufacturers, as well as a considerable segment of the physician population, are opposed to Federal law in this regard. Valid arguments obtain on both sides, to be sure. Is it not probably true, however, that the most sensible solution is, in effect, a compromise?

The profession and the public have become oriented, for good reason, in this area as in all fields of merchandising to place faith in a given product because of estabished reliability of the manufacturer. The same attitude applies to automobiles, electric appliances, foodstuffs, clothing, and all the goods and services of our abundant American economy. A discourse on "what's in a name" is beyond the scope of this message, but it must be obvious that a great deal of our current existence is based on the recognition that the "name" does indeed guarantee a certain standard of quality. Major pharmaceutical companies have contributed enormously to research in the drug field to develop products of sustained high quality. It seems to me that the physician should not be denied the right to specify which proprietary drug he desires to use in the treatment of an ailment of a given patient. All patients do not react or respond to the same drug in the same way.

Volume purchase of drugs by generic designation may promote economy in hospital or clinic operations. This practice, however, may not be to the best interest of every patient but it could make a less costly drug available to the physician when it does fit the patient's needs. In institutions where the practice is in effect, it should be by and with the assent of the medical staffs and not by Federal regulation. Requiring generic name prescription of all drugs, to my mind, is unjustified, unnecessary, and a further encroachment of Government in the practice of medicine.—Henry D. Ecker, M. D., in Medical Annals of the District of Columbia.

GENERAL NEWS



20th Annual Rural Health Conference At Jackson's Mill on Oct. 5

"Partnership For Rural Health" is the theme for the 20th Annual Rural Health Conference which will be held at Jackson's Mill on Thursday, October 5.

Miss Mildred Fizer

N. H. Dyer, M. D.

More than 300 persons are expected to attend the Conference which is sponsored annually by the West Virginia State Medical Association in cooperation with the Cooperative Extension Service of West Virginia University, the West Virginia Farm Bureau, the State Department of Health and the West Virginia Home Demonstration Council.

Dr. Martha Jane Coyner of Harrisville, who is in charge of this year's Conference, will call the meeting to order in the Assembly Hall promptly at 10:00 A. M.

Doctor Coyner announced that the morning session would be devoted to a program outlining the "Cooperative Health Education Projects by the Appalachian Center and School of Medicine, West Virginia University."

The first speaker will be Miss Mildred Fizer, State Chairman of the 4-H and Youth Development Programs of the West Virginia University Cooperative Extension Service.

Another speaker will be Miss Mary V. Pullen of Institute, who will outline the "Kanawha Area Pilot Projects."

Other speakers on the morning program will be two representatives from the Department of Preventive Medicine at the West Virginia University School of Medicine, and two 4-H club members who will discuss a program on "Who Helps With Health." The 4-H program was undertaken in an effort to develop an awareness of health problems, health facilities and health personnel in counties throughout the State.

Luncheon will be served in the Mount Vernon Dining Room at 12:15 P. M. with the West Virginia State Medical Association as host.

'New Approaches For Rural Health'

Dr. Richard V. Lynch, Jr., of Clarksburg, President of the State Medical Association, will deliver the address of welcome at the opening of the afternoon session.

The afternoon session will be devoted to a panel discussion dealing with the subject "New Approaches For Rural Health." Each of the participants will speak briefly and most of the session will be devoted to a question and answer period with active audience participation.

Dr. N. H. Dyer, State Director of Health, will serve as moderator and the other participants and their subjects will be as follows:

"Community Organization For Health."—Dr. Daniel Hale of Princeton.

Daniel Hamaty, M. D.

Martha J. Coyner, M. D.

"Multiphasic Screening Program."—Dr. I. E. Buff of Charleston.

"Solid Waste Disposal."—O. Raymond Lyons, Director of the Solid Waste Division of the State Health Department.

"Measles Immunization."—Arthur Schultz, Project Coordinator, Vaccination Assistance Projects, State Health Department.

"Home Health Services."—Dr. Daniel Hamaty, Director of the Division of Disease Control, State Health Department.

The Conference is open to the members of all interested groups and an invitation to attend the meeting

is being extended to members of local Farm Bureaus, home demonstration councils, agricultural extension workers and personnel of local health departments.

Advisory Committee

The program for the Conference was planned by members of the Advisory Committee to the State Medical Association's Rural Health Committee.

In addition to Doctor Coyner, the other members are Mrs. J. B. McCue of Summersville, President of the West Virginia Home Demonstration Council; Mrs. Sylvia C. Shapiro of Morgantown, State Extension Program Leader, Home Demonstration; Miss Gertrude Humphreys of Morgantown, former State Extension Home Demonstration Leader; Dr. N. H. Dyer, State Director of Health; Mrs. Rupert W. Powell of Fairmont, President of the Woman's Auxiliary to the State Medical Association; Mrs. Lynwood D. Zinn of Clarksburg, Chairman of the Auxiliary's Rural Health Committee; and Mr. E. O. Gregory of Buckhannon, Secretary of the West Virginia Farm Bureau.

Drs. Myers Return to Philippi After African Sevice

Dr. Karl J. Myers, Jr., and Dr. Mary Elizabeth Lawton Myers have returned to Philippi following 12 years of service as medical missionaries under the Southern Baptist Board in Ogbomosho, Nigeria, West Africa.

Doctor Myers, who is a Diplomate of the American Board of Internal Medicine, has joined the staff of The Myers Clinic and Broaddus Hospital in Philippi. His wife has limited her practice to pediatrics but will not be actively engaged in practice at the present time.

Kanawha Medical Sponsors Health Fair

The 1967 Health Fair, co-sponsored by the Kanawha Medical Society and the Community Council of the Kanawha Valley, will be held at the Charleston Civic Center, September 22-24.

More than 40 health and other organizations will have booths at the Fair.

Convention Story Will Appear In October Journal

The 100th Annual Meeting of the West Virginia State Medical Association was being held at The Greenbrier in White Sulphur Springs as this issue of *The Journal* went to press.

The full convention story, including information concerning new officers of both the State Medical Association and Auxiliary, as well as heads of sections and affiliated societies and associations, will be carried in the October issue.

Dr. Harold Selinger Named Chairman Of Coronary Care Task Force

A Task Force on Coronary Care, composed of cardiologists from different sections of the State, has been organized at the request of State Health Director N. H. Dyer.

The group met for the first time in Charleston on July 18. The purpose of the Task Force is to advise the State Health Department, as well as the physicians of West Virginia, of the direction in which the care of patients with coronary disease has taken throughout the country and the course it should take in West Virginia.

Chairman of the Task Force is Dr. Harold Selinger of Charleston. Other members are: Dr. N. Allen Dyer, Director of the Heart Disease Control Bureau of the State Health Department; Dr. William S. Sheils of Huntington; Dr. H. B. Sauder of Wheeling; Dr. H. D. Warren of Beckley; and Dr. Alphonse C. Edmundowicz of Morgantown, who represented Dr. Robert J. Marshall, Chief of Cardiology at the West Virginia University Medical Center, at the meeting.

Each of the members is involved in existing or planned coronary care units.

Three other physicians attended the July 18 meeting as advisors and consultants; They are: Dr. E. B. Cross, Director of the Coronary Disease Program of the U. S. Public Health Service; Dr. C. L. Wilbar of Morgantown, Director of the West Virginia Regional Medical Program for Heart Disease, Cancer and Stroke; and Dr. L. Torkelson, Regional Chronic Disease Consultant for the Public Health Service.

The Committee discussed the advisability of establishing coronary care units throughout the State. It is in the process of attempting to establish standards for coronary care units, as well as standards for a unified training program for physicians and nurses in coronary care and cardiopulmonary resuscitation.

Once the standards have been established, the programs will be presented on a regional basis.

State Tuberculosis Association Plans Annual Meeting

The annual meeting of the West Virginia Tuberculosis and Health Association will be held at the Holiday Inn in Princeton on Thursday, September 21.

The West Virginia Conference of Tuberculosis Workers will have its annual dinner and business meeting on Wednesday evening, September 20. The West Virginia Thoracic Society, the Association's professional medical branch will meet Thursday morning.

Although the complete program had not been arranged as *The Journal* went to press, one of the speakers will be Dr. Robert J. Anderson of New York, Medical Director of the American Thoracic Society.

Additional information about the meeting may be obtained by writing to Mr. Thomas A. Deveny, Jr., Executive Director, West Virginia Tuberculosis and Health Association, P. O. Box 341, Charleston, West Virginia 25322.

AAGP Announces Program For 19th Meeting

The treatment and management of the young cardiac and sexual aberrations will be among the major discussion topics at the 19th Annual Scientific Assembly of the American Academy of General Practice this month.

The Assembly, expected to draw some 3,000 family physicians and 10,000 visitors, will be held in Dallas, Texas, September 18-21. Twenty-six speakers are scheduled for the four-day program.

Also included will be the popular "bedside" clinical refresher courses, to be conducted by the faculty of Southwestern Medical College. These courses will cover topics of specific, practical interest to family doctors and will utilize the patients and facilities of seven Dallas hospitals.

Dr. James L. Grobe, Chairman of the Academy's Mental Health Committee, will head a three-man panel which will discuss "Sexual Aberrations." Other panelists will be Dr. Dana L. Farnsworth, Director of University Health Services at Harvard University; and Dr. S. H. Frazier, Professor of Psychiatry at Baylor University. The discussion will be on Thursday, September 21.

Four physicians will discuss "The Young Cardiac" on September 19. They are Drs. Jack C. Redman, Herman J. Smith, H. Gunther Bucheleres and George Griffith.

Attendance at the lecture program offers 14 hours of approved postgraduate credit to Academy members. They can earn a total of 19 or more hours of credit at the Assembly by attending all lectures and special courses.

The scientific program will follow the annual meeting of the AAGP's Congress of Delegates, September 16-18. Drs. Carl B. Hall and Seigle W. Parks, both of Charleston, will represent the West Virginia AAGP Chapter at the Congress of Delegates meeting.

BRT Medical Society Conducts Postgraduate Session

The 18th Annual Postgraduate Session of the Barbour-Randolph-Tucker Medical Society was held at the Elks Country Club in Elkins on June 29.

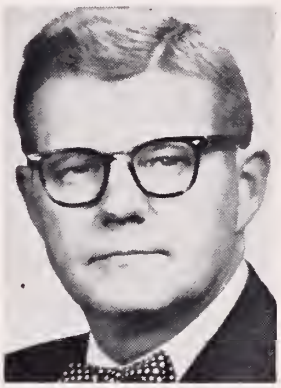
Psychiatric problems arising in non-psychiatric medical practice provided the discussion topic.

Speakers included: Dr. John Smith, Associate Professor of Psychiatry at the West Virginia University School of Medicine; Dr. John B. Reinhart, Associate Professor of Pediatrics and Child Psychiatry at the University of Pittsburgh School of Medicine; and Dr. Frank J. Ayd, Jr., Editor of the International Drug Therapy Newsletter.

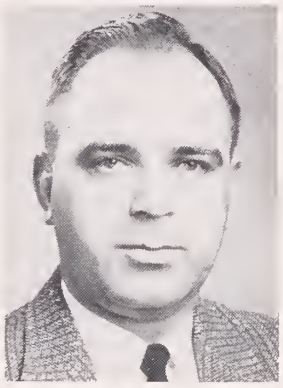
There was a banquet in the evening, with Dr. Karl J. Myers of Philippi serving as toastmaster. The banquet speaker was Dr. Cornelia Wilbur, Superintendent of Weston State Hospital, whose topic was "Present State of Mental Health in West Virginia."

West Virginia Heart Association Meeting in Wheeling

The annual meeting and scientific sessions of the West Virginia Heart Association will be held at Oglebay Park in Wheeling, Friday and Saturday, September 29-30.



Herbert E. Warden, M. D.



A. C. Edmundowicz, M. D.

Dr. Herbert E. Warden of Morgantown, President of the Association, will give an address of welcome prior to the beginning of the scientific sessions on Friday morning. Dr. H. B. Sauder, President of the Wheeling Heart Association, also will give a welcoming address.

The morning scientific session will consist of three papers on intensive coronary care and three on cardiopulmonary resuscitation. In the afternoon, the discussion topic will be the management of heart block.

A social hour and the annual membership and awards banquet will be held Friday evening.

The Saturday morning program will feature a meeting of the General Assembly of Delegates and members. Following a keynote address by Doctor Warden, there will be panel discussions on membership; local heart organization; local heart activities; coronary care units; and future structure of the American Heart Association and its affiliates. Each panel will report recommendations to the General Assembly in the afternoon.

The Board of Directors will meet Saturday evening, and the agenda will include the election of officers for the coming year. Dr. A. C. Edmundowicz of Morgantown is President Elect of the group.

Physicians may make reservations for the meeting by contacting the West Virginia Heart Association, 159 West Washington Street, Charleston, West Virginia 25302.

Cleveland Clinic Lists PG Courses

The Cleveland Clinic Educational Foundation has announced its 1967-68 program of postgraduate medical education courses.

The first course, entitled "Medical Technology," will be conducted on September 15.

Other information may be obtained by writing to the Director of Education, 2020 East 93rd Street, Cleveland, Ohio 44106

Doctor Dyer Urges Youth To Stop Smoking

State Health Director N. H. Dyer has called upon physicians, as well as parents, schools, churches, health departments, and community agencies, to discourage children from starting to smoke and to influence youth who are smoking to discontinue the habit.

In a recent issue of the "State of the State's Health," the health official discussed the recent controversy caused by a directive issued by the Cigarette Tax Division to all cigarette retail dealers and cigarette vending machine operators reminding them of the existing cigarette and smoking law. According to the law, cigarettes are not to be sold to any person under the age of 21, and it is unlawful to sell cigars, pipe or tobacco in any form to any person under the age of 16. The law carries a fine of $10 to $25 for first offense violators.

Doctor Dyer emphasized that the smoking of cigarettes does constitute a definite risk to health. He pointed to U. S. Public Health Service surveys which show that there is no longer any question but that cigarette smokers are more likely to contract certain diseases than nonsmokers—chronic illness, heart conditions, chronic bronchitis and/or emphysema, sinusitis, peptic ulcers—and that the death rates of smokers are greater than those of nonsmokers of the same age. He said that smoking is also associated with lung cancer and cancer of the larynx, and is believed to be related to cancer of the bladder, esophagus, and oral cavity.

The health director spoke of an anti-smoking committee formed in 1964 by the Health Department and the State Department of Education to discover, among other things, how many secondary school children were smoking in our State. A questionnaire was sent to 379 public and parochial secondary schools, and almost 56 per cent were completed and returned. The survey pointed up that from 3 to 30 per cent of secondary school students smoked at that time. More boys than girls smoked and a higher percentage of urban pupils indulged in the habit than rural. About half of those who smoked said they had their parents' consent. Far more than half of the students polled believed smoking was harmful.

"When we review the reasons why people smoke—to relax, to be sociable, to control weight, for personal pleasure, to combat boredom—we see that none are good enough to merit the continuation of smoking," he said. "None are good enough to shorten life expectancy."

Doctor Dyer explained that a law to keep persons under a certain age from smoking is necessary because youngsters can't or won't take the responsibility for their own health. "If we can keep them from smoking until they are old enough to realize the harm they are doing, we can drastically cut down on the total number of smokers," he asserted.

"Perhaps the age limit of the law should be altered," he said. "Perhaps a standard age should be set for driving a car, voting, meeting the military obligation, and buying liquor or cigarettes. However, a law restricting the sale of cigarettes is needed and some age will have to be designated. Whether the age should be 21, 18, 16 or lower, rests with the Legislature. As long as the present law continues to exist, it should be enforced."

Pediatric Training Program Announced by Wyeth

Applications are now available for two-year Wyeth Pediatric Fellowships for residencies beginning July 1, 1968.

Sponsored by the Wyeth Fund for Postgraduate Medical Education, each fellowship provides $4,800 over two years toward the advanced training required for board certification in pediatrics. Wyeth does not participate in the selection of recipients. In the first nine years of the program, 176 physicians have received assistance.

Interns, physicians who have recently completed an internship, research fellows, or physicians completing their tour of duty with the Armed Services or the U. S. Public Health Service are eligible to apply. Applicants must be citizens of the United States or Canada, and those who have already started pediatric residency training are not eligible.

Each fellow may choose the hospital in which he will train, provided that it is accredited by the Residency Review Committee.

Dr. Philip S. Barba, Past President of the American Academy of Pediatrics, is Chairman of the Selection Committee. Applications and other information may be obtained by writing to Doctor Barba at 120 Erdenheim Road, Philadelphia, Pennsylvania 19118.

Doctors Drinkard and Flink On ACP Committees

Two members of the West Virginia State Medical Association have been appointed to committees of the American College of Physicians for 1967-68.

Dr. Robert U. Drinkard, Jr., of Wheeling is one of four ACP members appointed to a task force which is working with the American Psychiatric Association.

Dr. Edmund B. Flink of Morgantown is a member of the Committee on Postgraduate Courses, a special committee of the Board of Governors. Doctor Flink also serves as ACP Governor for West Virginia.

New Marshall University Physician

Dr. Donald G. Klinestiver, a native of Keyser, has been appointed Director of the Marshall University Student Health Service, succeeding Dr. Craig T. McKee, who retired.

Doctor Klinestiver received his M. D. degree from the West Virginia University School of Medicine, and served an internship at Cabell-Huntington Hospital. He returned recently from Viet Nam, where he served as a medical officer assigned to the 101st Airborne Division.

New Association Members

Dr. John Osborne, 10 Water Street, Stonington, Connecticut (Kanawha). Doctor Osborne, a native of Kenova, was graduated from Morris Harvey College in 1958 and received his M. D. degree from the WVU School of Medicine in 1965. He interned at Charleston Memorial Hospital, 1965-66, and he is currently on active duty at the Navy Submarine Medical School in New London, Connecticut.

* * * *

Dr. William C. Simmons, Box 218, Gilbert (Mingo). Doctor Simmons, a native of Salina, Kansas, was graduated from the University of Kansas in 1956 and received his M. D. degree in 1960 from the University of Kansas Medical School. He interned at Bethany Hospital, Kansas City, Kansas, 1960-61. He served with the Army National Guard for six years and he is engaged in general practice.

* * * *

Dr. J. G. Vasquez, High Street, Grantsville (Parkersburg Academy). Doctor Vasquez, a native of New York City, was graduated from the University of Puerto Rico in 1950 and received his M. D. degree in 1954 from the School of Medicine of Puerto Rico. He interned at Hospital Santo Asilo de Damas, Ponce, Puerto Rico, 1954-55. He served with the U. S. Army, 1956-58, and he is engaged in general practice.

* * * *

Dr. Paul Eugene Walker, Appalachian Regional Hospital, Williamson (Mingo). Doctor Walker, a native of Monterey, Tennessee, was graduated from the University of Tennessee in 1926 and received his M. D. degree from the University of Tennessee School of Medicine in 1931. He interned at Baptist Memorial Hospital, Memphis, Tennessee, 1932-33, and served a residency with the U. S. Public Health Service, 1933-36. Doctor Walker did postgraduate work at the University of Maryland, University of Washington and Temple University. He served for 28 years with the U. S. Public Health Service and the United States Coast Guard. His specialty is general surgery.

* * * *

Dr. Robert R. Weiler, Central Union Building, Wheeling (Ohio). Doctor Weiler, a native of Wheeling, was graduated from Harvard in 1955 and received his M. D. degree in 1959 from the Medical College of Virginia. He interned and served a residency at Allegheny General Hospital in Pittsburgh, 1959-64. He served with the Medical Corps of the United States Navy, 1964-66, and his specialty is orthopedic surgery.

* * * *

Dr. John J. Yaeger, The Greenbrier Clinic, White Sulphur Springs (Greenbrier). Doctor Yaeger, a native of Trenton, New Jersey, was graduated from Temple University and received his M. D. degree from the Georgetown University School of Medicine in 1944. He interned at St. Francis Hospital in Trenton, New Jersey, 1944-45, and served residencies at Gallinger Hospital in Washington and Johns Hopkins Hospital in Baltimore. He served with the Medical Corps of the United States Army and his specialty is radiology.

Nursing Education Progams Supported by AMA

The American Medical Association has reiterated its support for all approved forms of nursing education programs.

A resolution adopted by the House of Delegates during the AMA meeting in Atlantic City in June noted that "the national trend . . . appears to be the gradual phasing out of the diploma schools of nursing and the transfer of nursing education to collegiate institutions."

The resolution pointed out that 70 per cent of the nursing care at the present time is rendered by graduates of diploma schools.

The AMA reaffirmed "its support of all forms of nursing education including baccalaureate, diploma, associate, and practical nurse education programs."

Furthermore, hospitals conducting diploma programs were "urged to continue their schools and increase enrollment while allowing the individual to choose the kind of nursing education he or she desires."

ACCP Announces Clinical Meeting In Houston

The American College of Chest Physicians will conduct its interim clinical meeting in Houston, Texas, November 25-26.

As usual, the meeting will precede the clinical meeting of the American Medical Association.

The program will consist of a two-day scientific program with round table discussions and fireside conferences. A highlight will be a panel discussion on "Cardiorespiratory System and Space Flight" which will be conducted at the NASA Manned Spacecraft Center.

A copy of the program and other details may be obtained by writing to Executive Office, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois 60611.

Psychiatric Hospital Starts Building Project

Groundbreaking ceremonies were held on July 27 for a $650,000 expansion of the St. Albans Psychiatric Hospital in Radford, Virginia.

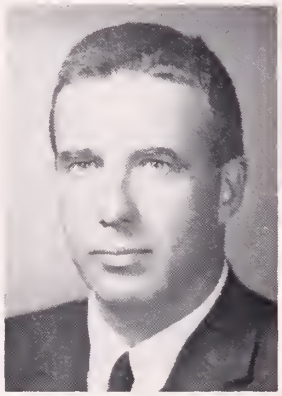
One of the principal features of the 33,000 square-foot addition will be a greatly enlarged dietary department which will more than triple the present feeding capacity of 44 patients at a time.

Also included in the plans for the four-story structure are administrative offices, a waiting room and conference rooms. Twelve new patient beds will be added, enlarging capacity to 158 patients.

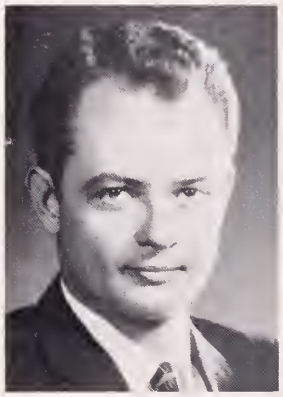
Administrator Donald Phillips said the addition should be completed late in 1968. He added that the hospital will bear the entire cost of the construction, but the cost to patients should not increase.

Bluefield Sanitarium Lists Annual Seminar

The Bluefield Sanitarium and two affiliated clinics will sponsor their 15th Annual Seminar at the Bluefield Country Club on October 12.



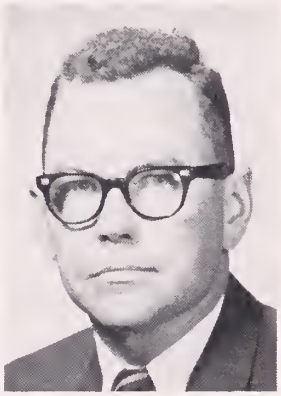
David M. Hume, M. D.



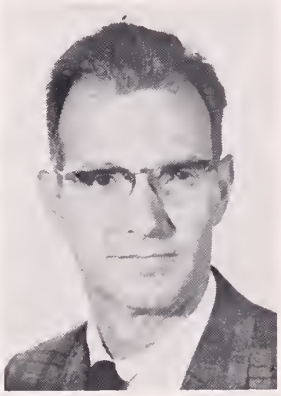
J. G. Smith, Jr., M. D.

Five speakers have been engaged for the Seminar, which will consist of a scientific program in the afternoon and a social hour and dinner in the evening. The after dinner speaker will be Mr. L. C. Lundstrom of Warren, Michigan, Director of Automotive Safety Engineering at the General Motors Technical Center.

The speakers at the scientific session will be as follows: Dr. David M. Hume, Chairman of the Department of Surgery at the Medical College of Virginia in Richmond; Dr. J. Graham Smith, Jr., Associate Professor of Dermatology at Duke University Medical Center in Durham, North Carolina, and Chairman-designate of the Department of Dermatology, Medical College of Georgia in Augusta; Dr. Richard O. Rogers, Jr., of the Department of Internal Medicine, Bluefield Sanitarium; and Dr. Robert F. Heimburger, Chairman of the Department of Neurosurgery, University of Indiana Medical Center.



R. O. Rogers, Jr., M. D.



Robert F. Heimburger, M. D.

Co-sponsoring the program with Bluefield Sanitarium are The Clinch Valley Clinic in Richlands, Virginia, and the Stevens Clinic in Welch. The scientific program will begin at 2:30 P. M., with the social hour scheduled for 6 P. M. and the dinner at 7 P. M.

All members of the West Virginia State Medical Association are invited to attend. No reservations are necessary for the scientific program, but those who plan to attend the dinner should contact Dr. Charles D. Pruett at the Bluefield Sanitarium in Bluefield.

Dr. Esposito to Present Course At EENT Meeting

Dr. Albert C. Esposito of Huntington will conduct an instructional course at the annual meeting of the American Academy of Ophthalmology and Otolaryngology which will be held in Chicago, October 28 through November 4.

Doctor Esposito's course is called "General Anesthesia and Ocular Surgery," and it covers the techniques he uses in general anesthesia in cataract and other ocular surgical procedures plus the changes in ocular surgical technique that are recommended when using these agents.

A Past President of the West Virginia State Medical Association and the West Virginia Academy of Ophthalmology and Otolaryngology, Doctor Esposito is now serving as the Secretary of the American Association of Ophthalmology.

The meeting in Chicago is expected to draw more than 8,000 eye, ear, nose and throat specialists from throughout the country.

Symposium on Chest Diseases In Charleston, Dec. 10

The West Virginia University Medical Center and the West Virginia Tuberculosis and Health Association are cosponsoring a Symposium on Chest Diseases in Charleston on Sunday, December 10.

The sponsors have reserved a block of tickets for the West Virginia University-Florida basketball game, which will be played in Charleston on the preceding evening.

Other information about the meeting may be obtained by writing to Dr. Charles E. Andrews, Department of Medicine, WVU Medical Center, Morgantown, West Virginia 26505; or to Mr. Thomas A. Deveny, Jr., Executive Director, West Virginia Tuberculosis and Health Association, P. O. Box 341, Charleston, West Virginia 25322.

Three-Day Course at MCV

A three-day course on "The Emergency Care and Transportation of the Seriously Ill and Injured" will be held at the Medical College of Virginia in Richmond, October 19-21.

The course, which is intended for firemen, policemen, emergency squads and public health and civil defense personnel, will be sponsored by the Committee on Injuries of the American Academy of Orthopaedic Surgeons in cooperation with the MCV Department of Continuing Education.

Further information may be obtained by writing to Dr. Virgil R. May, Jr., 2222 Monument Avenue, Richmond, Virginia.

American Medical Association Lists Two Meetings

The American Medical Association has announced programs for its 27th Annual Congress on Occupational Health and the 11th National Conference on Physicians and Schools.

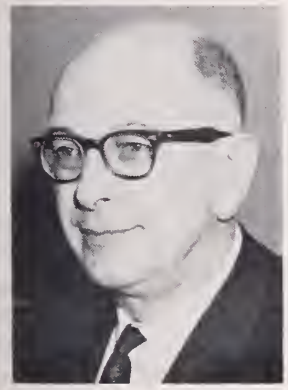
The Occupational Health Congress will be held in Atlanta, Georgia, September 25-26, under the sponsorship of the AMA's Council on Occupational Health. Conferees will examine problems in eight key areas including: occupational health in agriculture, epidemiology of occupational medicine, responsibility of the physician in off-the-job accident prevention, and cooperation between medical societies and workmen's compensation administrators.

The Conference on Physicians and Schools will be held in Chicago, October 4-7, under the sponsorship of the AMA Department of Health Education.

Additional details about either meeting may be obtained by writing to the appropriate Council or Department, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Industrial Medical Assn. Lists Pittsburgh Meeting

The Industrial Medical Association of the Pittsburgh-Cleveland Area will conduct its fall scientific meeting at Mellon Institute in Pittsburgh on September 8.



Seigle W. Parks, M. D.

Dr. Seigle W. Parks of Charleston, a Past President of the West Virginia State Medical Association, is President Elect of the group and will be installed as President at the meeting.

Speakers and their topics are as follows:

"Industrial Hygiene Programs"—Lester Cralley, Ph.D., Chief Industrial Hygienist, Aluminum Company of America.

"Air Pollution Control"—Victor H. Sussman, Director of the Division of Air Pollution Control, Pennsylvania Department of Health.

"Parasitic Diseases in Metropolitan U.S.A."—H. W. Brown, M. D., Professor of Parasitology, College of Physicians and Surgeons, Columbia University.

"Keep the Eyes Right for the Job"—Joseph F. Novak, M. D., Clinical Assistant Professor of Ophthalmology, University of Pittsburgh School of Medicine.

Additional information about the meeting may be obtained by writing to Dr. E. A. McGovern, Pittsburgh Works Division, Jones and Laughlin Steel Corporation, 2812 East Carson Street, Pittsburgh, Pennsylvania 15203.

Cabell Symposium Will Explore 'The Adolescent'

"The Adolescent" will be the subject for the annual Symposium of the Cabell County Medical Society, which will be held at the Hotel Frederick in Huntington on Thursday, September 14.

Edward M. Litin, M. D.

Thomas E. Shaffer, M. D.

Four speakers from out-of-state will present papers at the symposium, which will begin at 9 A. M. and end by 5 P. M.

The speakers and their topics are as follows:

"Some Normals and Abnormals in Adolescent Growth and Development"—C. Andrew Rigg, M. D., Children's Hospital of the District of Columbia.

"Menstrual Disorders of the Adolescent"—Warren R. Lang, M. D., Department of Obstetrics and Gynecology, Jefferson Medical College, Philadelphia.

"The Adolescent Athlete"—Thomas E. Shaffer, M. D., Department of Pediatrics, Ohio State University College of Medicine, Columbus.

"Emotional Problems of the Adolescent"—Edward M. Litin, M. D., Department of Psychiatry, The Mayo Clinic, Rochester, Minnesota.

Additional details about the meeting may be obtained by contacting Dr. William L. Neal, 213 First Huntington National Bank Building, Huntington, West Virginia 25701.

American College of Physicians Calls for Abstracts

The American College of Physicians has called for abstracts of papers proposed for presentation at the 49th Annual Session of the ACP, which will be held in Boston, April 1-5, 1968.

The Committee on Scientific Program will accept abstracts of original contributions in the following general areas: cardiovascular; gastroenterology; pulmonary; endocrinology and metabolism; hematology; infectious diseases and allergy; rhumatology and immunology; renal and electrolytes; neurology and psychiatry; and neoplasia.

The official form containing rules for submission of abstracts is being published in issues of *Annals of Internal Medicine*.

ACP Announces PG Courses For 1967-68

The American College of Physicians has announced a series of 21 postgraduate medical education courses it will conduct during 1967-68.

Tuition fees include $60 for each course for ACP members and $100 for nonmembers.

The complete schedule is as follows:

Sept. 18-21—"Hematology: Current Concepts and Developments," Los Angeles.

Oct. 2-6—"Clinical Cardiology," Loma Linda, California.

Oct. 9-13—"Renal Diseases and Fluid and Electrolyte Balance," Seattle.

Nov. 15-18—"Neurologic Aspects of Internal Medicine," Durham, North Carolina.

Nov. 27-30—"Medical Genetics," Ann Arbor, Michigan.

Dec. 4-8—"Radio-Isotopes and Nuclear Radiations in Medicine," Berkeley, California.

Dec. 11-15—"Advances in Medical Oncology," Houston, Texas.

Jan. 15-19—"Neurology and the Internist," Miami Beach.

Feb. 5-9—"Psychiatry and the Internist," Los Angeles.

Feb. 19-23—"Intensive Care Units," Cincinnati.

Feb. 28-Mar. 2—"Hypertensive Cardiovascular Diseases: Mechanisms and Treatment," Montreal.

Mar. 14-16—"The Clinical Selection of Patients for Cardiac Surgery," Rochester, Minnesota.

Mar. 18-22—"Psychiatry and the Internist," Albany, New York.

Mar. 27-30—"Current Concepts in Physiology of Respiration, Circulation and Electrolyte Metabolism," Boston.

Apr. 22-26—"Clinical Endocrinology — Recent Advances in Diagnosis and Treatment," Rochester, Minnesota.

May 12-15—"Frontiers in Gastroenterology," Philadelphia.

May 20-24—"The Prevention and Early Detection of Disease in Clinical Practice," Philadelphia.

May 27-31—"Auscultation of the Heart," Philadelphia.

June 10-14—"Basic Principles in Internal Medicine—1968," Iowa City, Iowa.

June 17-19—"Intensive Care Units," Denver.

June 19-21—"Infectious Diseases—Mechanisms and Manifestations," Baltimore.

Additional information may be obtained by contacting Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania.

Wrong Cure—"We may never cure poverty, but with prices and taxes the way they are, we're sure going to cure wealth."—Apalachicola (Florida) Times.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1967

Sept. 7-9—Am. Assn. of Ob. and Gyn., Hot Springs, Va.
Sept. 8-9—Maryland Medical, Ocean City.
Sept. 9—PG Course in "Cardiac Auscultation Review," South Charleston.
Sept. 15-23—AAGP, Dallas.
Sept. 22-29—Col. of Am. Pathologists, Chicago.
Sept. 26-28—Ky. Medical, Louisville.
Sept. 27-30—Penn. Medical, Philadelphia.
Sept. 29-Oct. 1—W. Va. Heart Assn., Wheeling.
Sept. 29-Oct. 3—Am. Soc. of Anes., Las Vegas.
Oct. 2-6—ACS, Chicago.
Oct. 5—Rural Health Conf., Jackson's Mill.
Oct. 5-7—Assn. of Am. Phys. & Sur., Houston.
Oct. 12—Bluefield Sanitarium Seminar, Bluefield.
Oct. 19-21—Va. Medical, Alexandria.
Oct. 20-24—Am. Heart Assn., San Francisco.
Oct. 21-26—Am. Acad. of Ped., Washington.
Oct. 25-28—Cong. of Neurological Sur., San Francisco.
Oct. 29—Am. Assn. of Oph., Chicago.
Oct. 29-Nov. 3—Am. Acad. of Oph. and Otol., Chicago.
Oct. 27-29—Potomac-Shenandoah PG Institute, Martinsburg.
Nov. 13-16—Southern Medical, Miami Beach.
Nov. 16-19—Nat. Soc. for Crippled Children & Adults, Los Angeles.
Nov. 25-26—Am. Col. of Chest Phys., Houston, Texas.
Nov. 26-29—AMA Clinical Meeting, Houston, Texas.
Nov. 29-Dec. 3—Am. Med. Women's Assn., Atlanta.
Dec. 2-7—Am. Acad. of Dermatology, Chicago.
Dec. 4-6—Sou. Surgical Assn., Hot Springs, Va.

1968

Jan. 17-18—Am. Rheumatism Assn., Baltimore.
Jan. 20-25—Am. Acad. of Orthopaedic Surgeons, Chicago.
Jan. 29-31—Soc. of Thoracic Sur., New Orleans.
Feb. 3-7—Am. Acad. of Allergy, Boston.
Feb. 6-10—Am. Col. of Radiology, Chicago.
Feb. 28-March 3—Am. Col. of Cardiology, San Francisco.
March 18-20—Am. Acad. of Ped., Atlanta.
March 24-29—Am. Col. of Allergists, Denver.
March 29-31—Am. Soc. of Int. Med., Boston.
April 1-5—ACP, Boston.
April 16-19—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 17-19—Maryland Medical, Baltimore.
April 22-24—Am. Assn. for Thoracic Surg., Pittsburgh.
April 22-25—Am. Col. of Ob. & Gyn., Chicago.
April 25-26—Am. Hosp. Assn., Hollywood, Fla.
May 1-2—Am. Ped. Soc., Atlantic City.
May 7-8—Assn. of Am. Phys., Atlantic City.
May 12-17—Am. Psy. Assn., Boston.
May 13-16—Am. Urological Assn., Miami Beach.
May 14-17—Ohio Medical, Cincinnati.
May 19-22—Nat. TB Assn., Houston.
May 23-25—Am. Gyn. Soc., Hot Springs, Va.
June 15—Acad. of TB Phys., San Francisco.
June 15-16—Am. Diabetes Assn., San Francisco.
June 16-20—Am. Col. of Chest Phys., San Francisco.
June 16-20—Am. Col. of Preventive Med., San Francisco.
June 16-20—AMA, San Francisco.
June 20-22—Am. Med. Women's Assn., San Francisco.
June 26-27—Am. Geriatrics Soc., New Orleans.

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Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
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warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
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(alcohol 0.69%)
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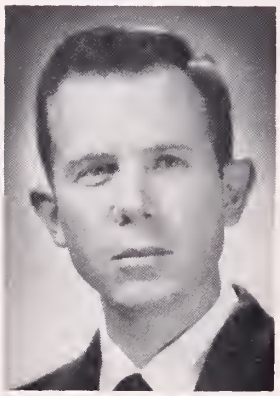
WVU Medical Center
—News—

The appointment of Dr. Wilford Wayne Spradlin of Durham, North Carolina, as Professor and Chairman of the Department of Psychiatry has been announced by Dr. Harry B. Heflin, Acting President of WVU.



Wilford W. Spradlin, M. D.

Doctor Spradlin assumed the position on August 15, succeeding Dr. Robert Vosburg, who resigned.

A native of Virginia, Doctor Spradlin went to WVU from the Duke University Medical Center, where he served as Assistant Professor of Psychiatry, Chief of the Psychiatric Day Unit and Assistant Head of the Psychiatric Inpatient Service.

He attended Ferrum Junior College in Virginia and then the University of Virginia, where he received his B.A. degree in 1953 and his M.D. degree four years later. He served his internship at Royal Victoria Hospital in Montreal, and began his residency training in psychiatry in 1958 at Eastern State Hospital in Williamsburg, Virginia.

Doctor Spradlin is certified by the American Board of Psychiatry and Neurology. His major research interests concern the physiological changes noted in the nervous system with various disease states, the role of psychiatry services in the care of patients with rehabilitation problems, the potential of day units in the treatment of psychiatric patients and the utilization of drama as an adjunct to therapy.

New Otolaryngologist

Dr. Charles T. Yarington, Jr., a native of Sayre, Pennsylvania, joined the School of Medicine faculty on July 1 as Assistant Professor of Otolaryngology.

Doctor Yarington was graduated from The Hill School, Princeton University, and received his M. D. degree in 1960 from Hahnemann Medical College. He interned at Rochester General Hospital and completed a residency in otolaryngology at the University of Rochester Medical Center.

For two years prior to his appointment to his present position, Doctor Yarington was an officer in the Medical Corps of the U. S. Army.

Doctor Yarington is a Fellow of the Royal Society of Medicine (London), the American Academy of Ophthalmology and Otolaryngology, the Association of Military Otolaryngologists and the Roches Academy of Medicine.

He is the author or co-author of 40 articles published in scientific journals.

• **Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.**

New Physicians in Department of Medicine

Two new appointments to the Department of Medicine faculty were effective July 1.

Dr. William Keith Campbell Morgan, a native of England, was named Associate Professor. He also will serve as Chief of the Medical Research Station for Appalachian Laboratory for Occupational Diseases, which is located at the Medical Center.

Doctor Morgan earned his medical degrees (M. B. Ch. B. and M. D.) at Sheffield University. For a time he was engaged in general practice in England and held the rank of Captain in the Royal Army Medical Corps.

He joined the University of Maryland School of Medicine in 1958 and was an Associate Professor there at the time of his appointment to the WVU post.

Dr. William James Tate III was appointed Instructor in Medicine and Chief of the Infectious Diseases Unit of the Appalachian Laboratory for Occupational Respiratory Diseases.

A native of Connecticut, Doctor Tate attended Yale University and received his M. D. degree from Boston University in 1961. He completed a residency in medicine at Yale-New Haven Medical Center in 1964.

For three years prior to his recent appointment, Doctor Tate was Research Fellow in Infectious Diseases at the University of Pittsburgh School of Medicine.

Biochemist Named

Dr. Harold Resnick was appointed Associate Professor of Biochemistry, effective July 1. He also will hold the title of Chief of the Biochemistry Unit at the Appalachian Laboratory for Occupational Respiratory Diseases.

Doctor Resnick is a native of Brooklyn. He received his B.S. degree from the College of the City of New York and a master's degree from Brooklyn College. He was awarded his doctorate in biochemistry in 1959 at the State University of Iowa.

He most recently was Assistant Professor of Biochemistry at the University of Arkansas Medical Center.

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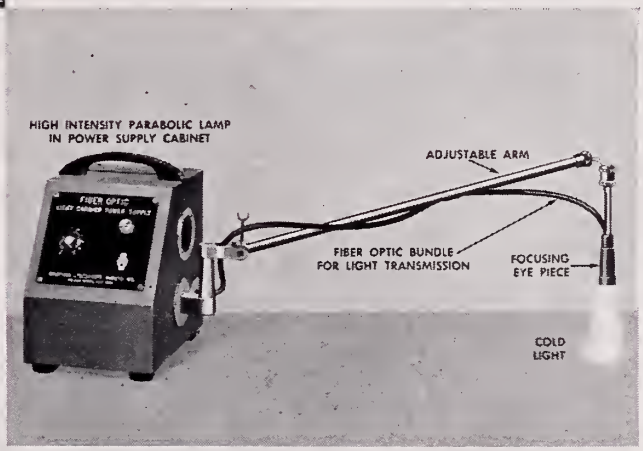
Additional light carrier bundles for special uses are also available, in 1/8, 1/4 and 3/8-inch diameter, in 72-inch lengths.



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The Month in Washington

THE House Ways and Means Committee approved a Social Security bill including some Medicare and Medicaid changes sought by the medical profession and excluding others opposed by the American Medical Association.

The Committee also discarded an Administration proposal to extend Medicare coverage to disabled workers under age 65, as well as an Administration-opposed proposal that would have put federal government workers under Medicare. The actions were part of a general scaling down of the increases in Social Security benefits sought by President Johnson.

A Committee bill (H. R. 12080) included these changes in the present law:

—Allow Medicare patients, or doctors, to collect from the government on the basis of an itemized bill. Present law requires a bill receipted as having been paid to the doctor if the doctor doesn't accept an assignment (AMA-supported).

—Authorize states to allow physicians to bill Medicaid patients directly if they are not also cash assistance recipients (AMA-supported).

—Eliminate the requirement for certification by a doctor before admission of a Medicare patient to a hospital (AMA-supported).

—Shift coverage on Medicare outpatient diagnostic services provided by hospitals from Plan A to Plan B (AMA-supported).

—Put limits on federal contributions to states for Medicaid programs. Beginning July 1, 1968, the federal ceiling on eligibility would be 150 per cent of the annual income set by a state for welfare eligibility. It would drop to 140 per cent on January 1, 1969, and to 133⅓ per cent January 1, 1970.

—Require states to give birth control information to welfare patients who request it.

In addition to opposing extension of Medicare to disabled workers under age 65, the AMA opposed creation of a new Plan C under Medicare and a provision for chiropractor's services—both of which were rejected by the Committee.

The House group slashed back the President's proposal for a 15 per cent minimum monthly Social Security increase in cash benefits to 12.5 per cent. The administration proposal for an increase in Social Security taxes also was scaled down to 4.4 per cent, on the employer and on the employee, of the first $7,600 in wages starting in 1968. The taxable wage base now is $6,000, and the tax rate is 4.4 per cent. The Administration had asked that the base be increased to $7,800 next year, and in later stages, to $10,800.

• **From the Washington Office of the American Medical Association.**

Community Blood Banks

The American Medical Association and the Kansas City Community Blood Bank asked Congress to exempt community blood banks from the anti-trust laws.

Representatives of the groups testified at a Senate Judiciary Subcommittee hearing in support of S. 1945 which would amend the anti-trust laws to provide that a non-profit blood or tissue bank, or hospital, or physician who refuses or who joins together with others in refusing to obtain or to accept delivery of blood, blood plasma, other tissue or organs from any other blood or tissue bank would not be in restraint of trade. The interstate shipment of blood, blood plasma, other tissue or organs also would not be deemed to constitute trade or commerce in commodities.

The legislation was introduced after the Federal Trade Commission ruled that a group of Kansas City pathologists, hospitals and blood bank officials had combined illegally to restrain commerce in human whole blood. An appeal against the ruling is pending in the Federal Eighth Circuit Court of Appeals in St. Louis, Missouri.

Dr. Robert S. Mosser, President of the Kansas City Blood Bank, said it was inconceivable that groups of physicians may not have the right to discuss shortcomings of medical practice, including the use of blood and its derivatives.

Dr. Frank C. Coleman, Tampa, Florida, pathologist, presented the views of the AMA:

"Because serious health hazards may arise through transfusion by virtue of the medical condition of the donor, the care necessary in the selection of blood donors by blood banking facilities cannot be overemphasized. Serious consequences may arise unless the blood is properly drawn, processed, stored and distributed. And it is imperative that these procedures be performed under high standards, under the guidance and control of proper medical supervision."

Doctor Coleman pointed out that the AMA in 1963 adopted a statement "to the effect that the transfusion of blood constitutes the transplant of human tissue, and that physicians responsible for transfusions render a medical service to the patient."

SAINT ALBANS
PSYCHIATRIC HOSPITAL

Radford, Virginia

James P. King, M. D., Director

William D. Keck, M. D.
Clinical Director
James K. Morrow, M. D.
Morgan E. Scott, M. D.

Clinical Psychology:
Thomas C. Camp, Ph. D.
Card McGraw, Ph. D.
David F. Strahley, Ph. D.

Edward E. Cale, M. D.
Malcolm G. MacAulay, M. D.
Don L. Weston, M. D.
J. William Giesen, M. D.

Don Phillips, Administrator
R. Lindsay Shuff, M. H. A.
Asst. Administrator
Social Service:
Harold M. Cook, M.S.W.

AFFILIATED CLINICS

Bluefield Mental Health Center
525 Bland St., Bluefield, W. Va.
David M. Wayne, M. D.

Beckley Mental Health Center
109 E. Main Street, Beckley, W. Va.
W. E. Wilkinson, M. D.

Mental Health Clinic
Professional Building, Wise, Va.
Pierce D. Nelson, M. D.

Obituaries

RAY IRA FRAME, M. D.

Dr. Ray I. Frame, 67, died at his home in Madison on July 25.

A native of Sutton, Doctor Frame had practiced medicine in the Madison and Sharples areas for more than 40 years.

He received his B.S. degree from West Virginia University in 1921 and was awarded his M.D. degree in 1924 at Jefferson Medical College of Philadelphia. He served his internship at Grant Hospital in Columbus, Ohio, and took advanced training at New York Postgraduate Hospital and School.

He was a former Secretary of the Kanawha Medical Society and transferred his membership to the Boone County Medical Society in 1960. Doctor Frame also was a member of the West Virginia State Medical Association and the American Medical Association.

Survivors include a son, William Ray Frame of Ellicott City, Maryland; a daughter, Mrs. Fanny Gray Buxton of Silver Springs, Maryland; a brother, David, of Sutton; and a sister, Mrs. Ella Crouch of Ellicott City, Maryland.

Family Planning Conference In Charleston

A West Virginia Family Planning Conference will be held at the Charleston Civic Center, Thursday and Friday, September 7-8.

The program has been arranged for physicians, nurses, social workers, hospital personnel, public health workers and volunteers. Sponsors include the West Virginia Economic Opportunity Agency, the West Virginia Department of Health, the West Virginia Department of Welfare, and Planned Parenthood—World Population, Southeastern Region.

Among participants will be: State Welfare Commissioner L. L. Vincent; State Sen. Paul J. Kaufman of Charleston; and Drs. Walter A. Bonney, Jr., of Morgantown, Jane Freeman of Charleston, Mildred Mitchell-Bateman of Charleston, and Thomas Nale of Huntington.

Dr. Sprinkle Lectures in Scotland

Dr. Philip M. Sprinkle of Morgantown presented a paper on "Diseases and Tumors of the Salivary Glands" at the Royal Victoria Hospital in Edinburg, Scotland, in August.

Doctor Sprinkle is Associate Professor and Chairman of the Division of Otolaryngology at the West Virginia University School of Medicine.

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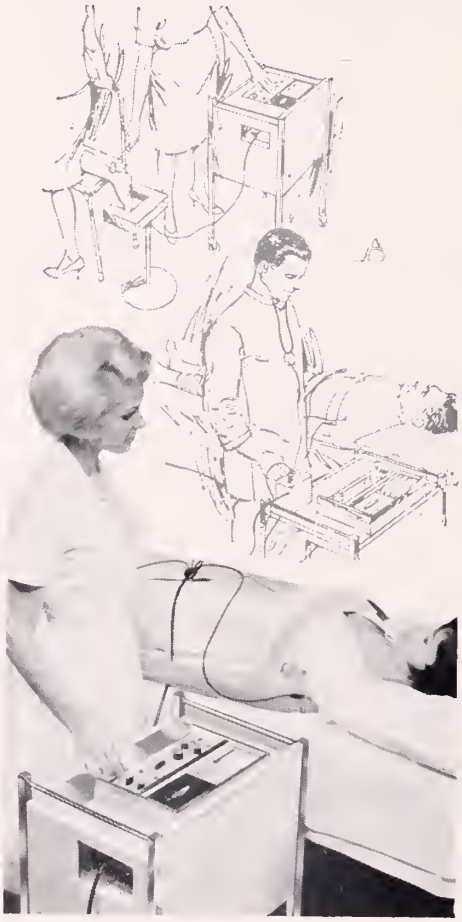

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Book Reviews

NEW DRUGS—1967 Edition—Published by the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

The 1967 Annual Edition of "New Drugs" includes all information concerning new drugs and most of the drugs introduced in the past decade.

"New Drugs" is in no sense a list of "New and Accepted Drugs."

In the *Annual* drugs are discussed and grouped according to their function. There are 51 groupings, beginning with antibacterial agents. This 50-page chapter, devoted to antimicrobics is a thorough investigation into the uses, actions, reactions, precautions, dosage and preparation. The section on the penicillins is especially valuable to physicians who wish to be selective in this field of antibiotic therapy.

The 51 sections include the latest information and directives on such old medication as expectorants to the newest enzymes.

Each chapter contains a general discussion of the subject with a detailed description of the recent additions to the particular therapy. Special attention seems to be given to adverse reactions and precautions.

This is a handy reference book designed to assist the physician in his decisions concerning new and sometimes dangerous drugs.

To quote from the book, "The inclusion of a drug in "New Drugs" does not imply that the Council accepts, endorses, recommends, or guarantees any individual brand or preparation of this evaluated drug. Neither is it logical or reasonable criterion for approving the use of that drug in any institution or any other purpose."

★ ★ ★ ★

HEARTS—Their Long Follow Up—By: Paul Dudley White, M. D. and Helen Donovan. W. B. Saunders Company, Philadelphia, London. 1967. Pp 357. Illustrated. Price: $12.00.

Doctor White prefaces this book with the statement that, "two cardiological subjects which have particularly attracted my attention during the last decade and which have appealed to medical groups to whom I have spoken are the 'Long Followup', a much neglected kind of research, and 'Cardiology in my Time', a decade by decade account of our growing knowledge in the field."

Doctor White in his introductory case emphasizes the ability of the patient to recover from serious heart disease no matter what the cause as soon as the acute process has subsided and the possible reversibility of every kind of heart disease; and that one can grow healthier as one gets older and not necessarily the reverse.

The follow-up relates to the general history and physical findings, more especially, rate, blood pressure, size, sounds, murmurs and ECG findings.

There are 20 chapters devoted to various types of heart disease illustrated by 80 case histories and

63 electrocardiograms and films. The arrangement of the book permits the physician to read and enjoy the particular problem that interests him at that time. Each chapter is a complete essay in itself with history and illustrations and the book can be relished at each reading without loss of continuity of thought or presentation.

In L'Envoi, Doctor White speaks of the rehabilitation of the body, mind and soul of so many patients who a half century ago or less would have been considered hopelessly crippled.

The book reads easily as do all of Doctor White's publications, and many physicians will find it a most interesting study for reference and casual reading.

* * * *

RADIOLOGY IN WORLD WAR II—Edited by Kenneth D. A. Allen, M. D., and prepared and published under the direction of Lt. Gen. Leonard D. Heaton, The Surgeon General, United States Army. Available from Superintendent of Documents, Government Printing Office, Washington, D. C. 20402. Pp. 1132, with numerous illustrations, charts and maps. Price: $8.25.

This book is quite interesting and reads like a novel rather than a dry history book as the title would indicate. It is divided into seven parts dealing with military radiology before World War II, radiology in the Zone of the Interior (United States), Mediterranean Theater, European Theater, Asiatic-Pacific Theater, Minor Commands, and the Atomic Bomb.

To the older radiologist, who enjoyed his service experience, it will be full of pleasant nostalgia; to

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those few who did not, it will give them an opportunity to say "I knew they shouldn't have done it that way." To the younger radiologist it will be very interesting to learn of the early developments in the careers of currently prominent radiologists. To West Virginians it will give a feeling of pride to read of the work of Harold I. Amory, M. D., currently Professor of Radiology at the West Virginia University, while he was at Walter Reed Army Hospital. To the man responsible for future planning for military radiology the book is a valuable chronicle of predecessors' mistakes and triumphs.

It is particularly interesting to see the variety of difficult conditions under which radiology can be practiced. The every day problems of spare parts, electricity of proper voltage and cycle, making a darkroom, combating mud, heat and humidity, of fantastic variation in patient load, and of the many other difficulties not even considered in a civilian practice.

It is quite pleasing to read of the cooperation among medical and para-medical personnel. The devoted service of radiologic technologists to their radiologists is inspiring. Far beyond producing radiographs under difficult and occasionally hazardous conditions, they improvised x-ray equipment from more conventional military hardware and obtained many needed items via the "moonlight supply route." The way radiologists would take advantage of educational opportunities when they were available such as in England, France and Australia, is typical of professional men. The formation of medical societies and even radiological societies in remote areas to further the professional abilities of their members is also inspiring.

The section on the Atomic Bomb and its effects is quite impressive. If these photos could be more widely disseminated, there would be more negotiation and less military conflict.

An enjoyable book, an informative book, a practical book and a real buy for $8.25.—Ray A. Harron, M. D.

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Additional information may be obtained by writing to Dr. R. N. Grant, Coordinator, Sixth National Cancer Conference, American Cancer Society, 219 East 42nd Street, New York City, New York 10017.

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Dr. Charles H. McKeena of the U. S. Public Health Service's Communicable Disease Center was guest speaker at the regular monthly meeting of the Cabell County Medical Society, which was held at the Holiday Inn in Huntington on June 8.

Doctor McKeena presented an interesting paper on "Infectious Syphilis and Drug Resistent Gonnorrhea." Active discussion followed the lecture.

The Society congratulated one of its members, Dr. C. A. Hoffman of Huntington, on his recent elevation to the presidency of the American Urological Association.

Thirty-seven members and guests attended the meeting—Harold N. Kagan, M. D., Secretary.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

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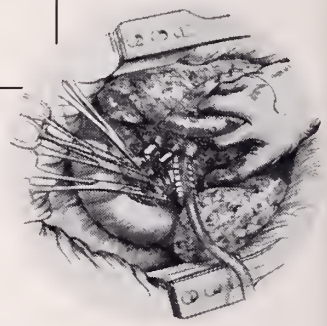

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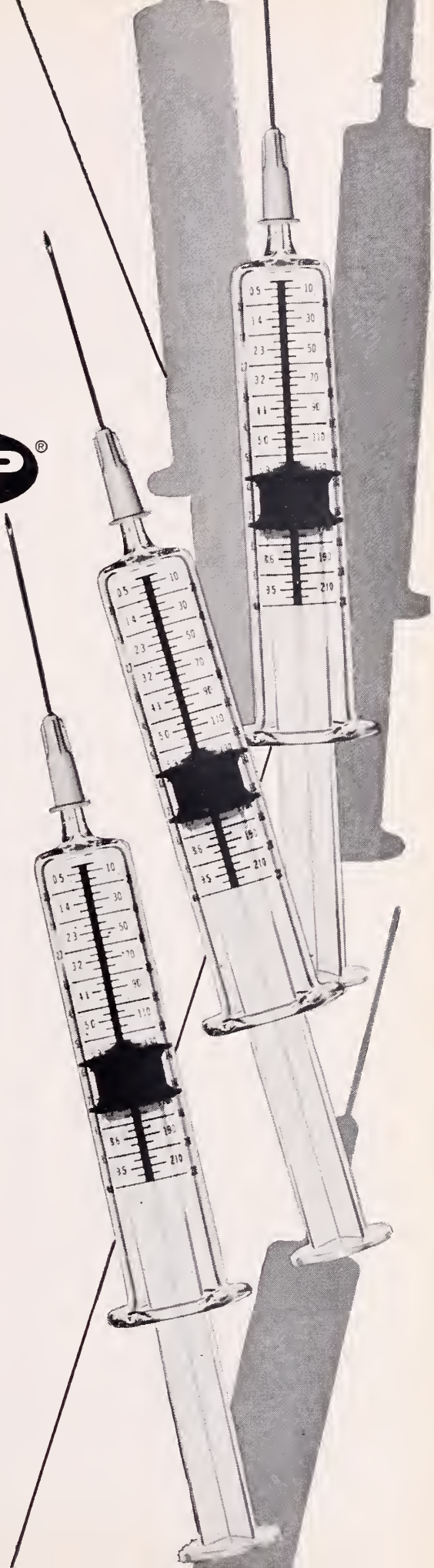

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The
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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50c per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

Member 1967

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The West Virginia Medical Journal

Vol. 63, No. 10 October, 1967

The State of the Association*

Richard E. Flood, M. D.

It took some patience on my part to sit down and organize the thoughts I have collected over the past 12 months for this occasion. But having been a part of many audiences myself, I also realize it takes some degree of patience to listen. I have made many talks during my year as President of the West Virginia State Medical Association. For the most part, I have limited them to five or ten minutes, so no one can accuse me of being too verbose. I can assure you that I do not plan to depart from this unwritten rule as I give you this report on the "State of the Association."

First, I want to say I shall be forever grateful for the great honor you bestowed on me, and the trust you placed in me, one year ago when I took the oath of office. Since that day, I have logged thousands of miles on land and in the air from Atlantic City to Las Vegas, from Washington to Chicago, and many points in between as your official representative.

Despite the necessary personal sacrifices, such as being away from the office and home frequently, I have enjoyed every minute of it. Our younger generation might put it a different way: "I've had a ball." I am sure Dick Lynch will agree one year from now when he presents his report.

I am especially pleased to have been your President during this centennial year and to preside at this great Centennial Meeting. Planning this memorable occasion has demanded considerable time and effort on the part of many of our members and their wives, and for this, my thanks for a job well done.

During this past year, we have tried to reconstruct the first 100 years of our Association and to commemorate certain red-letter dates in our history. Dr. George F. Evans, the highly competent editor of our *Journal*, spent many hours reading and studying some of our musty old documents. From these he constructed a series of historical abstracts which were published in several issues of *The Journal*.

Last February 28, many of us gathered in the great city of Wheeling where the seeds of our Association had been planted 100 years ago to the day. With the Ohio County Medical Society in charge of arrangements, we paid tribute to those few men who on February 28, 1867, drafted a convention call that ultimately led to the founding of our Association.

Then, on April 10, we were the guests of the Marion County Medical Society in the great city of Fairmont. It was on that same day in the year 1867 that our first annual convention was called to order. Distinguished guests at the anniversary meeting included the Surgeon General of the U.S. Public Health Service, Dr. William Stewart, and a Past President of the American Medical Association, Dr. James Z. Appel of Pennsylvania. On behalf of the AMA, Doctor Appel presented us with a scroll, which is on display at this meeting.

For the past year, a beautiful blue, gold and black seal has been the motif for our centennial year. This seal was designed for us by my friend, Mr. Mitchell Sagan of Weirton, who also painted

The Author

- **Richard E. Flood, M. D., Immediate Past President of the West Virginia State Medical Association.**

*Annual Address of the President, West Virginia State Medical Association, 100th Annual Meeting, The Greenbrier, White Sulphur Springs, August 26, 1967.

the seals you see behind me. I am pleased that Mr. Sagan could be with us at this meeting.

Of course, all this has been only the historical and ceremonial side of my year as President of the State Medical Association. I would be remiss in my duties if I did not report on the present state of the Association and to share with you some of my ideas for the future.

Among my more pleasant duties was traveling about the state, visiting with and talking to our county medical societies. I am proud of the fact that I was able to accept every invitation. I did, however, have to cancel out Monongalia County because of a severe winter snowstorm that prevented my attendance at the eleventh hour.

I had to field many questions during these visits. And I soon learned that just about the same things were on everyone's mind. How is Medicare going? How can we get more doctors? When am I going to get my usual and customary charges from the Welfare Department and other third-party agencies? These are a few of the questions that were asked most frequently.

Medicare

For years, organized medicine waged a great fight against Social Security medical insurance. Two years ago, we lost the great battle. But like good physicians and good American citizens, we dressed our wounds and decided that since Public Law 89-97 was the law of the land, we would abide by the law and cooperate. However, we made it clear that we would point to the flaws and shortcomings and offer suggestions for therapy.

With the enactment of Title XIX, the Federal Government in effect told us we were being liberated from having to accept inferior or low fees because there was no longer going to be such a creature as a charity patient. Needless to say, it has not worked exactly this way. Various third-party agencies—and I am referring especially to State and Federal Government agencies—are always confronting us with a "fee schedule."

Usual and Customary Charges

When you or I buy a car or a house, we pay a price that is acceptable to the seller or provider. It cuts exactly the opposite with the government third parties. They are quoting prices that are acceptable to the purchaser.

And this raises another interesting question. Why should architects, builders, manufacturers and distributors wax fat on the profits of doing business with the government when we, as physicians, are asked to accept charges that sometimes do not even pay our overhead?

All of us have accepted cut-rate charges from third parties in the past. But has the Government ever granted any sort of reciprocity?

Let me give you an example. In a manner of speaking, the Department of Motor Vehicles charges "a usual and customary fee" of five dollars for a driver's license, and 20 dollars for a license plate for a rather light car. Now I ask you in all seriousness—can you today go to 1800 Washington Street East in Charleston and purchase a driver's license for two dollars and a license plate for 10 dollars? We all know the answer to that. But did it ever occur to you that when the coin is turned, that is exactly what the Government is asking us to do?

Regular Charges Urged

One year ago, in this very same auditorium, this House of Delegates officially urged the members of our Association to accept only their usual and customary charges for third parties. This is vitally important. I plead with you to put this principle into practice if you have not already done so. We need the cooperation of each and every member of the State Medical Association who has a private practice and who deals with third parties.

It is just not fair to either the doctor or the patient if the doctor charges his private patients six dollars for an office call; one third party agency, four dollars, and yet another, three dollars.

Charity

Physicians have historically been charitable. It takes a strong sense of charity to be a doctor. We have been generous with our time and efforts to the communities in which we live, the civic and professional organizations to which we belong and those of our patients who are much less fortunate than we. Let us remember this and continue to live up to it. But let us also remember that charity belongs to the relationship between the doctor, the patient and God—and not to the relationship between the doctor, the patient and the Government.

And so I urge you to accept only your usual and customary charges from third parties. Where charity toward a particular patient is indicated, let charity prevail.

High Level of Medical Practice

In my travels throughout this State, I have found the level of medical practice to be generally high. But the doctors of West Virginia need help. It is interesting to note that not too many years ago, medicine was a rather competitive profession. In fact, this Association of ours some

years back was considering ways to cut back on the output of doctors from our medical schools.

Fifty years ago, 1,025 physicians belonged to our Association. In the past half-century, despite a large increase in our own population, we have had a net gain of about 300 members.

Naturally, with modern transportation and modern medical techniques, the doctor of today is able to care for more patients than his counterpart of 50 years ago. Nevertheless, the supply of doctors in this State is not keeping up with the demand for medical service. There are certain areas of the state where it is not convenient to become ill because there is no doctor for miles around. And we are finding that many of our native West Virginians are going to other states to practice medicine. We are, in fact, losing doctors.

How To "Get a Doctor"

The West Virginia State Medical Association is frequently asked: "How can we get a doctor?" There is no sure-fire remedy or pat answer to this.

I do believe that what is needed is a personal relationship between practicing physicians and our young people who plan to be doctors. I believe that every single county medical society should take steps to find out what young men and women from their areas are in medical school and where they are. Once this information has been gathered, we as practicing physicians should establish a personal, friendly relationship with these people. We need to let them know that they are not only welcome but wanted here in West Virginia. We need to maintain contact with them throughout their medical education. We need to be salesmen selling these young men and women on the idea that their services are in demand at home.

The West Virginia State Medical Association has taken a special interest in the doctor shortage in rural areas through its medical scholarship program. Even if this program were to reach optimum efficiency within its limited financial framework, no more than a dent in the problem would be made.

Ideas as to how the Scholarship Fund should be operated have been tossed back and forth. Perhaps we are approaching the time when a committee should take a look at this program and report back to the Council and the House of Delegates.

AMA Caucuses

The West Virginia State Medical Association is represented in the AMA House of Delegates by two very fine men whose influence in that body far exceeds their number. One is a member of the important AMA Council on Medical Service and the other is what you might call the permanent treasurer of a subsidiary organization of the House called "Aces and Deuces." Our Council has pretty much given these two members a free hand in the AMA House deliberations. Only on a few occasions has any rumbling been made to those whom they represent.

However, I believe that for the betterment of all, there should be regular caucus sessions of West Virginia physicians at AMA meetings. All members of our Association attending the meetings should be invited to attend these caucuses to express their views on pending business. We did this on a limited scale at the AMA meeting in Atlantic City two months ago, and it proved successful.

State Office Analysis

I feel that we have a competent staff in our state office in Charleston. But possibly a review of our administrative operations is in order. It has occurred to me that it might be worthwhile to retain some independent agency to survey our office operations. This agency would be asked to answer such questions as: Do we need a full-time director of public relations? Do we need more secretarial help? Do we need more office space? With the answers to these and other questions in hand, a special committee might be formed for long-range planning.

Health Professions Alliance

Last month, I had the honor of being a guest speaker at the annual convention of the West Virginia Pharmaceutical Association here at The Greenbrier. My appearance at that meeting was prompted by the fact that this is the 100th anniversary of our Association.

I proposed to the pharmacists—and I renew this proposal now—that we in the health professions organize a formal alliance. This alliance would include representatives of the medical, pharmaceutical, nursing, dental, osteopathic and other recognized health professions. The formal organizational structure might consist of two or three members of each group comprising a board or a committee.

Such an organization could be useful in many ways. For one thing, it might serve to counterbalance the tremendous influence that organized labor exerts in the political arena. But unlike organized labor, ours would be a non-striking alliance that could advise our members on political matters and not tell them how they must vote.

This proposal seemed to be well received by the Pharmaceutical Association. And it is my fervent hope that our own Council will take the initiative and begin building this alliance of the health professions in West Virginia.

Support for AMPAC-WESPAC

There are other ways we doctors may be more effective politically. I am sure all know that a political action group known as WESPAC—The West Virginia Medical Political Action Committee—exists. It is affiliated with the American Medical Political Action Committee.

The membership is composed of members of both of our great political parties. The object is not to elect all Republicans or all Democrats to Congress and other offices. The purpose of these political action groups is to elect friendly candidates and unseat unfriendly incumbents. This is not to say that AMPAC and WESPAC necessarily support candidates who "vote medicine" straight down the line. Rather, the object is to elect candidates of both political parties who will at least sit down with representatives of organized medicine, listen to their ideas, then vote their conscience.

I support AMPAC and WESPAC, and I strongly urge each and every one of you to do the same. A membership is just $25 a year. Part goes to AMPAC and part is kept by WESPAC. We have representatives of both committees with us, and they will be more than happy to sign you up. If you cannot find one of them, I shall be happy to accept your membership personally and see that it gets to the proper person.

Auxiliary Praised

I could not bring my term as President to a close without mentioning one of the hardest-working group of women I know. I am referring, of course, to our own Auxiliary, which has enjoyed a very successful year under the presidency of Mrs. Hu C. Myers. Our Auxiliary members have distinguished themselves this year by winning top awards in national competition for contributions to AMA-ERF. One award was made in Atlantic City last June to the West Virginia Auxiliary for turning in the largest contribution from an organization in the 1,000 to 1,500-member class.

I am especially proud of the Auxiliary to my own Hancock County Medical Society, which reported the largest total contribution and the largest per-capita contribution in a unit with up to 25 members. Words cannot express my pride in these fine women.

Summary

Before I turn this office over to my successor, I would like to underscore some of the ideas I wish to leave with you. First, I urge you in the strongest of terms to accept only your usual and customary charges for service from third-party agencies. Secondly, we need to get personally involved in the recruitment of doctors for our State. Thirdly, I believe the West Virginia State Medical Association should be the prime mover in the formation of an alliance of all the ethical health professions in the State. And lastly, AMPAC and WESPAC need your support.

At this moment, I feel like a first cousin to Old Father Time. I feel that I represent in a way the end of an era—the first century of the West Virginia State Medical Association.

Doctor Lynch, who in a few moments will be sworn in as my successor, probably feels like a New Year's babe because he represents the beginning of the second hundred years. To my good friend, Dick Lynch, I offer my best wishes for a happy and successful year. I hope that he will receive the same courtesy and support that I have enjoyed these last 12 months.

My term as President is now over, but I look forward to many more years of service to the West Virginia State Medical Association in other capacities. Holding this office has been one of the high points in my life. I will be forever grateful to each of you for giving me this great privilege.

ACID & AIR

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Relief of hyperacidity is still a primary goal in the treatment of peptic ulcer. And antacids are the most widely used means of achieving this relief. But antacids alone cannot influence the distention and bloating which so often add to ulcer distress.

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Perhaps there have been times when you wanted to prescribe erythromycin and triple sulfas for little patients. Now you can—with a choice of two new fine-tasting pediatric forms.

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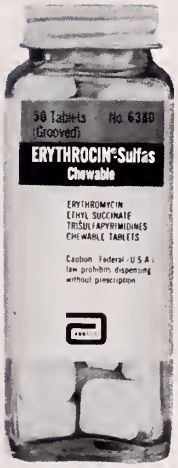

ERYTHROCIN®-SULFAS Chewable (Erythromycin ethyl succinate-trisulfapyrimidines chewable tablet)

In clinical trials[1,2], this orange-flavored tablet was given to 55 patients, aged four months to 18 years.

Diagnoses (multiple in some cases) represented a cross section of bacterial infections commonly seen in pediatric office practice.

Therapy was given from three to 12 days, with an average of six days.

Of the 55 patients, 30 were reported cured within 72 hours, while 22 showed partial recovery within the same time, and subsequent clinical cure.

A clinical cure rate of 94.5%

ERYTHROCIN®-SULFAS Granules (Erythromycin ethyl succinate-trisulfapyrimidines granules for oral suspension)

87 patients were treated[1,2]—all children, ages four months to 15 years.

The diagnoses were multiple in some cases and were chiefly bacterial infections of the respiratory tract.

Dosage was maintained from three to 10 days; average treatment was five days. All of the ill children accepted the orange-flavored suspension favorably.

53 were clinically cured within 72 hours, while 32 showed partial relief within the same time, and subsequent clinical cure.

701358

A clinical cure rate of 97.7%

1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

ABBOTT

Brief Summary on next page

ERYTHROCIN®-SULFAS
Brief Summary

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or newborn infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions, Side Effects: Occasionally mild abdominal discomfort, nausea or vomiting may occur with erythromycin, generally controlled by reduction of dosage. Mild allergic reactions (such as urticaria and other skin rashes) may occur. Serious allergic reactions have been extremely infrequent. Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated. If overgrowth of nonsusceptible organisms occurs, withdraw the drug and institute appropriate treatment. If a patient should show signs of hypersensitivity, appropriate countermeasures (e.g. epinephrine, steriods, etc.) should be administered and the drug withdrawn.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. of each of sulfadiazine, sulfamerazine and sulfamethazine.

701358

ABBOTT

Differential Diagnosis of Anemia

Jerry A. Dorsch, M. D., Vicente Anido, M. D., and Rex B. Conn, Jr., M. D.

Anemia is a symptom, not a disease. Rational therapy requires precise diagnosis, and the anemic patient should have a thorough clinical and laboratory evaluation to ensure a definitive diagnosis. For most anemic patients the evaluation need not be elaborate or expensive. Diagnosis of certain types of anemia, however, may involve complicated laboratory procedures, and omission of these indispensable diagnostic aids, when indicated, frequently will result in inaccurate conclusions and improper treatment. As an aid to the differential diagnosis of anemia we have constructed a flow chart based on an etiological classification of anemia and including the pertinent laboratory and clinical findings used in differential diagnosis. The key to the chart is given in the lower left-hand corner.

Signs and Symptoms of Anemia

In simplest terms anemia is a condition in which there is decreased oxygen-carrying capacity of the blood secondary to decreased concentration of hemoglobin. The symptoms of anemia depend on any underlying disorders, the degree and rate of change in the total blood volume, and the extent of reduction in the oxygen-carrying capacity of the blood.

Anemia can produce an array of symptoms which may suggest a variety of systemic disorders. The clinical findings in anemia (listed at the top of the chart) may include general fatigue, breathlessness on exertion, dizziness, headache, pallor of the skin and mucous membranes, palpitation, functional systolic murmurs, anorexia, tingling in the fingers and toes, ankle edema and angina pectoris.

Confirmation of Anemia

Although anemia may be suspected after a careful history and physical examination, appropriate laboratory tests always should be performed to confirm the suspicion and to determine, if possible, the type of anemia present. Immediate "shotgun" treatment should be avoided because important complications could remain undetected and future laboratory tests might be invalidated. The most rewarding approach is to pursue the investigation of anemia systematically.

Submitted to the Publication Committee, March 21, 1967.

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A simple laboratory test can confirm the suspicion of anemia. The test which should be performed first is the hematocrit. It is quick and accurate and can be done routinely either by the microhematocrit or the Wintrobe method. The hemoglobin determination also is a good confirmatory test but is subject to more technical difficulties. The cyanmethemoglobin procedure for hemoglobin is the best method and should be used routinely. Other initial tests which should be made if anemia is present are listed on the chart. These include red cell count, white cell count, reticulocyte count, differential count and red cell indices. It is essential that the peripheral film be examined for abnormal erythrocyte size, shape, hemoglobin and inclusions.

Differential Diagnosis of Anemia

The anemias may be classified on the basis of etiology or red cell morphology. These classifications are complementary and usually are used together.

The three basic causes of anemia are blood loss, increased erythrocyte destruction and decreased erythrocyte production.[15] Although occasionally more than one mechanism may be operative, the first important step in differential diagnosis is to determine which of these mechanisms dominates, a question that usually can be resolved by the red cell indices and the reticulocyte count. The red cell indices are calculated from the hemoglobin, hematocrit and red cell count and can give a quantitative separation into the macrocytic, normocytic and microcytic anemias as shown in the first step

of the flow chart. Immediately in these three categories are the different conditions which might prove responsible, followed by the confirming laboratory tests and the results usually found in each condition. Generally, the simpler, less expensive tests should be done first.

Microcytic Anemia

In the microcytic anemias (MCV < 80 cubia micra), the erythrocytes usually are hypochromic (MCH < 27 micromicragrams) as well as smaller than normal, and the indices are all below the normal range.[5] Although most hypochromic microcytic anemias are due to iron deficiency, it is essential to find out the cause of the deficiency prior to treatment, since it may result from causes such as occult malignancy of the gastrointestinal tract, hiatus hernia, esophageal varices, gastritis or Meckel's diverticulum.[2] As noted in the chart, iron deficiency may be due also to dietary iron deficiency, excess demands such as childhood or pregnancy, chronic blood loss and malabsorption of iron. The history may reveal a diet low in iron or a condition resulting in chronic blood loss. Physical examination usually reveals paleness of skin. Papillary atrophy of the tongue may be present to some degree. A stool sample or rectal examination may be guaiac or benzidine positive for occult blood.

Examination of the blood smear in iron deficiency anemia reveals pale, light stained erythrocytes which are smaller than normal.

Measurement of the serum iron and iron binding capacity and examination of the marrow stained for iron with the Prussian blue stain will distinguish iron deficiency anemias from the other hypochromic, microcytic anemias.[1] In iron deficiency due to any cause, marrow iron stores and serum iron are decreased. Characteristically in infection, both the serum iron and iron binding capacity are decreased, while inadequate utilization of iron in pyridoxine deficiency and sideroblastic anemia is indicated by high serum iron levels and increased marrow iron stores.

If these tests indicate dietary iron deficiency, a therapeutic trial of oral ferrous sulfate is indicated for confirmation. There should be a reticulocyte response reaching a peak in eight days if the diagnosis is correct.[16] If the anemia is due to poor utilization or malabsorption of iron, oral iron is ineffective and the underlying cause must be found.

Macrocytic Anemia

If the initial cell indices show a mean corpuscular volume of greater than 99 cubic micra the anemia is considered macrocytic. Macrocytic anemia is not synonomous with pernicious anemia and if the erythrocyte indices indicate macrocytosis all possible causes should be considered in the differential diagnosis. The flow chart indicates these various conditions and the laboratory tests which can differentiate between them.[6] Macrocytic anemia is considered megaloblastic if megaloblasts, large immature nucleated red cells which show disparity between nuclear and cytoplasmic maturation, are found in the bone marrow.

Pernicious anemia is manifested by a megaloblastic anemia caused by a deficiency of vitamin B_{12}. This is due to defective absorption in the intestine because of a lack of gastric intrinsic factor. The symptoms are those common to all anemias, but a sore tongue and numbness and tingling of the extremities also are frequently noted. In addition to marked macrocytosis, anisocytosis and poikilocytosis, moderate leukopenia and thrombocytopenia often are present. Polymorphonuclear neutrophils show hypersegmented nuclei with more than six lobes. Gastric aspiration or a Diagnex Blue test[8] is used to determine the presence of achlorhydria. A Schilling test may be done to confirm the absence of intrinsic factor. Serum B_{12} assay and gastric mucosal biopsy[10] also can be helpful. The Schilling test or therapeutic trial with B_{12} should be performed only after other tests have been completed since many will be invalidated and difficulties in diagnosis may be increased. If a deficiency of folic acid is suspected,[4] low doses may be given as a diagnostic trial.[13] This is not good practice, however, because folic acid may correct the anemia but will have no effect on the progress of neurologic complications.

Patients with pernicious anemia should have clinical and hematological follow-up at six or twelve-month intervals to ensure that maintenance therapy is adequate. Cancer of the stomach shows an increased incidence in patients with this condition and must be considered in follow-up examinations.

Megaloblistic anemia can be associated also with tropical sprue, idiopathic steatorrhea and, occasionally, celiac disease, although the latter usually is accompanied by hypochromic-microcytic anemia. The fundamental defect is impaired and delayed intestinal absorption. The clinical symptoms are characterized by glossitis, diarrhea and the passing of light colored, bulky, foul smelling, voluminous stools with an elevated fat content. There is osteoporosis, infantilism and stunted growth. The bone marrow findings are of megaloblastic changes. Free hydrochloric acid generally is found in the stomach. The Schilling test shows no improvement after intrinsic factor is added, thereby differentiating

Headache
Pallor
Palpitation
Tachycardia
Anorexia
Edema
Fatigue
Lassitude
Dizziness
Breathlessness on exertion
Cardiac Enlargement
Faintness

ANEMIA

Hemoglobin
Hematocrit
Peripheral Smear
Red Cell Count
Red Cell Indices
Reticulocyte Count
White Cell Count
Differential
Platelet Estimate

MCV > 99 cμ, MCH > 31 μμg, MCHC 32-36%, Poikilocytosis, Normal no. retics

- **Nutritional Megaloblastic Anemia**
  - Dietary history, Radioactive B_{12} absorption, Serum B_{12}, Bone marrow
  - Poor dietary history, Vitamin B_{12} absorption good, Low serum B_{12}, Megaloblastic marrow
- **Pernicious Anemia**
  - Test for free HCl in stomach, Topfer's reagent, Diagnex blue, Histamine stimulation of gastric mucosa, Bone marrow, Schilling test, Serum B_{12}, Gastric biopsy
  - No free HCl, No HCl after histamine stimulation, Megaloblastic marrow, Schilling test: No intrinsic factor-low B_{12} uptake, Intrinsic factor added-uptake improved, Serum B_{12} low, Atrophy or deficiency of gastric mucosa
- **Steatorrhea**
  - Test for free HCl, Topfer's reagent, Diagnex blue test, d-xylose absorption test, Fecal fat determination, Bone marrow, Schilling test, Folic acid absorption test, Ca determination
  - Free HCl in stomach, Malabsorption present, Fecal fat elevated, Megaloblastic marrow, B_{12} and folic acid are absorbed, Ca low
- **Post Gastrectomy and Blind Loop Syndrome**
  - Clinical history, Serum B_{12}, Bone Marrow, Therapeutic trial with B_{12}
  - History of abdominal surgery, Low serum B_{12}, Megaloblastic bone marrow, Improvement on B_{12} injection
- **Megaloblastic Anemia of Pregnancy**
  - Pregnancy test, Histamine stimulation of gastric mucosa, Bone marrow, Course of disease, Folic acid trial
  - Continued pregnancy, HCl usually present, Megaloblastic marrow, Termination of pregnancy ends the anemia, Folic acid corrects the anemia
- **Macrocytic Anemia of Liver Disease**
  - Peripheral smear, Bone marrow, Gastric analysis, Serum iron, B_{12} or folic acid response
  - Mild anisocytosis and poikilocytosis, Marrow normal megaloblasts rare, HCl present, Serum iron increased, Poor response to B_{12} or folic acid
- **Diphyllobothrium latum Infection**
  - Stool Examination, Bone marrow, Serum B_{12}
  - Ova found in stool, Megaloblastic bone marrow, Serum B_{12} low
- **Drugs**
  - Therapeutic history, Serum B_{12}, Folic acid administration, Bone marrow
  - Administration of phenytoin sodium or pyrimidine Anti folic drugs, Serum B_{12} normal, Folic acid improvement, Megaloblastic marrow
- **Megaloblastic Anemia of Infancy**
  - Dietary history, Bone marrow, Therapy with folic acid
  - Smear: Anisocytosis, Poikilocytosis, Diet deficiency of folic acid with vitamin C, Megaloblastic marrow, Therapeutic response to folic acid

Reticulocytosis, Jaundice, Splenomegaly

- **Hemolytic Anemia**
  - Clinical findings: Indirect bilirubin, Urinary and fecal urobilinogen, Bone marrow, Red cell survival studies, Serum electrophoresis, Coombs test
  - Hemoglobinuria, Hemoglobinemia, Indirect bilirubin increased, Urobilinogen increased, Erythroid hyperplasia of marrow, Red cell survival decreased, Low serum haptoglobin
  - Coombs test positive
    - **Idiopathic Acquired Hemolytic Anemia**
      - Warm antibody
        - Smear examination, Osmotic fragility, Warm antibody
        - Anisocytosis, Poikilocytosis absent, Normoblasts, Leukocytes elevated, Thrombocytopenia, Osmotic fragility increased in acute phase and normal otherwise, Agglutination at 37°C
      - Cold antibody
        - Agglutination at cold temperature
        - Indirect Coombs positive at 20°C, Cold agglutinins present at 2°C
    - **Transfusion reaction**
    - **Immune Antibodies Erythroblastosis**
      - Antigen-antibody tests to determine offensive antigen
      - Rh, Kidd, Kell, Duffy, Lewis
  - Coombs test positive or negative
    - **Symptomatic Autoimmune Acquired**
      - Discovery of associated disease process
      - Lupus erythematosus, Leukemia, Lymphoma
    - **ABO Incompatibility of the Newborn**
      - Blood Smear: Evidence of ABO blood group incompatibility between mother and infant, Cold serum for antibodies of Anti A or Anti B type, Mother's serum for immune antibodies, Wiebsky or Moritz Anderson test on cord blood
      - Spherocytes, Presence of ABO incompatibility using mother's or infant's blood, Antibodies of Anti A or Anti B immune type
    - **Paroxysmal Cold Hemoglobinuria**
      - Rosenbach test, Ehrlich test, Donath Landsteiner test
      - All tests positive, Sideroses of kidney, Siderinuria
  - Coombs test negative
    - **Pernicious Anemia**
      - Rare component: Refer to: macrocytic anemia for diagnostic tests
    - **Infectious agents**
      - History of exposure to or clinical indication of:
      - Malaria, Bartonella, Clostridium, Streptococcus, Vibrio, Staphylococcus, E. coli, Viruses
    - **Chemical agents**
      - Exposure to or injection of
      - Benzene, Distilled H_2O
    - **Physical Agents**
      - Condition following
      - Uremia, Burns, Irradiation
    - **Other types**
      - Osmotic fragility, Cell survival
      - Cell survival decreased in donor patient (intracorpuscular defect)
      - Osmotic Fragility Increased
        - Hereditary Spherocytosis
          - Family history, Clinical history, Blood smear, Autohemolysis
          - Presence of the disease in other members, Gall stones, Spherocytes, Autohemolysis increased before and after incubation
      - Osmotic Fragility Normal
        - Hereditary Nonspherocytic Anemia
          - Blood smear, Enzyme studies
          - No spherocytes, Low pyruvate kinase level, Low G6PD activity plus glutathione instability, High G6PD activity plus abnormal glutathione stability
        - Paroxysmal Nocturnal Hemoglobinuria
          - Rous' test, Ham's test, Alkaline phosphatase, Acetylcholinesterase level in blood and serum
          - Rous' and Ham's test positive, Low leukocyte alkaline phosphatase, Acetylcholinesterase level decreased
      - Osmotic Fragility Decreased
        - Hemoglobinopathies
          - Sickle cell anemia
            - Sickle cell preparation, Blood smear, Bone marrow, Hemoglobin electrophoresis, X-ray, Iron uptake
            - Sickle cell prep shows sickling, Anisocytosis, Poikilocytosis, Marrow normoblastic hyperplasia, Hemoglobin S on electrophoresis, X ray trabecular pattern of bone, calcified spleen, Iron uptake increased
          - Hemoglobin C,D,E,G,H,I,J,K,L,N,O,P,Q
            - Paper or starch gel electrophoresis
            - Characteristic electrophoretic pattern for each
          - Thalassemia
            - Alkali denaturation test, X-ray, Electrophoresis, Plasma iron, Iron uptake
            - Resists alkali denaturation, Hair on end appearance of bone, Characteristic pattern of electrophoresis, Iron uptake decreased, Plasma iron increased

Leukocytosis

Leukopenia, Thrombocytopenia

- **Primary Refractory Anemia**
  - History of exposure to marrow depressing agents, Bone marrow, Other causes
  - Exposure to benzene, Organic arsenicals, Chloramphenicol, Mesantoin, Gold comp, Ionizing radiation, Tuberculosis, Fanconi syndrome, Marrow is aplastic or normal

MCV 80-99 Cμ, MCH 27-31 μμg, MCHC 33-38%

- **Myelophthisic Anemia**
  - Peripheral blood, Urine for Bence Jones protein, Bone marrow
  - Nucleated erythrocytes, Bence-Jones protein may be present, Marrow demonstrates tumor cells
- **Myelofibrosis**
  - Bone marrow, Splenic puncture
  - Marrow aplastic hypoplastic or normal, Myeloid metaplasia of spleen
- **Acute Blood Loss**
  - Clinical, Platelet count
  - Restlessness, Sweating, Thirst, Platelet increase (1 hr.), Polymorphonuclear leukocytes increase (2-5 hrs.), Hemoglobin and hematocrit dec (2-5 hrs.)
- **Simple Chronic Anemia**
  - Diagnosis by exclusion of other types of anemia and determination of the causative infection or malignancy
  - Some cases may show microcytic cells with normal hemoglobin content

MCV < 80 cμ, MCH < 27 μμg

- **Iron Deficiency**
  - Dietary history, Guaiac test, Benzidine test, GI investigation, Parasites, Serum iron, Iron binding capacity, Prussian blue stain of bone marrow, Therapeutic iron trial
  - Poor dietary history, Serum iron low, Iron binding capacity increased, No bone marrow iron stained by Prussian blue method, Response to oral iron
    - Dietary Iron Deficiency
  - Pregnancy, Rapid growth, Serum iron moderately depressed, Iron binding capacity increased, Bone marrow iron stores reduced
    - Excess Demands
  - Positive guaiac or benzidine test, Bleeding from GI tract, Hookworm ova, Low serum iron, Increased iron binding capacity
    - Chronic Blood Loss
  - Low serum iron, Increased iron binding capacity, No response to oral iron
    - Malabsorption
- **Thalassemia Major**
  - Refer to diagnostic tests under same heading in hemolytic anemia
- **Hypochromic Anemia of Infection or Uremia**
  - Serum iron, Iron binding capacity, Bone marrow stain
  - Low serum iron, Low iron binding capacity, Bone marrow iron stores increased
- **Pyridoxine Deficiency**
  - Pyridoxine administration, Serum iron, Bone marrow stain
  - Reticulocyte response, Increased serum iron, Increased bone marrow iron stores
- **Sideroblastic Anemia**
  - Bone marrow iron stain, Fe^{59} red cell utilization test, Serum iron
  - Sideroblastic granules, Normoblastic hyperplasia, Ineffective erythropoiesis, Bone marrow iron stores increased, Serum iron increased

KEY

Tentative or final diagnosis

Test or clinical information

Result of above test or clinical observation

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sprue from pernicious anemia.[14] Folic acid usually gives a good therapeutic response in tropical sprue and idiopathic steatorrhea.

Normochromic-Normocytic Anemia

A normochromic normocytic anemia (MCV 88-99 cubic micra, MCH 27-31 micromicrograms) is one in which there is no significant deviation from the normal in red cell volume or erythrocyte hemoglobin content. Clinical symptoms do not differ from those of anemia in general.

Normochromic anemia may be due to blood loss, decreased erythrocyte production or increased erythrocyte destruction (hemolysis). The reticulocyte count is the most valuable aid in differentiating between these causes since it usually is increased following blood loss and in the hemolytic anemias. The history and stool guaiac or benzidine tests are the most valuable procedures for differentiating blood loss anemias. Bone marrow examination should be done if a low reticulocyte count indicates decreased erythrocyte production since it usually will indicate the cause of the decreased production.

Normocytic Anemia With Hemolysis

A hemolytic anemia is one resulting from an increased rate of destruction of red cells. This may be due to an intracorpuscular abnormality causing the cells to be more susceptible to the normal destructive processes or to an extracorpuscular abnormality which destroys the red cells. Anemia results when the hemopoietic tissue no longer can compensate for the blood loss due to hemolysis[7] The chart shows the clinical and laboratory findings useful in differentiating the causes of hemolytic anemia.

The general symptoms of mild hemolytic anemia may be no more than slight dyspnea. In severe cases, however, gall stones and chronic leg ulcers may be complications. In acute forms of the disease there may be headache, restlessness, irritability, nausea and vomiting. Congenital forms may be relatively asymptomatic.

Physical findings may include varying degrees of jaundice, splenomegaly and bone changes on x-ray.

The laboratory findings common to all hemolytic anemias are increased indirect bilirubin and fecal urobilinogen, reticulocytosis, decreased red cell survival and proliferation of the erythroid elements of the bone marrow.

Idiopathic Acquired Hemolytic Anemia

Demonstrable antibodies on the red cells and in the serum are present in most patients with this disorder. Antibodies on the red cells may be demonstrated by the direct Coombs' test and in the serum by the indirect Coombs' test. Most often, they are incomplete antibodies and mainly of the warm type active at 37 C. Occasionally, they are of the cold type giving a positive Coombs' test at 20 C. or at 2 C. rather than at 37 C. Osmotic fragility is normal in remission and increased in acute phase. The other findings present are typical of hemolytic anemia.

Blood Incompatibility

A direct Coombs' usually is positive in Rh incompatibility in the newborn as well as following incompatible blood transfusions. These conditions can be easily differentiated.

Symptomatic Acquired Hemolytic Anemia

This type of hemolytic anemia is associated with some underlying disease, but the exact mechanism is not understood. Usually it occurs two weeks after the onset of some viral infection such as viral pneumonia or infectious mononucleosis. Auto-agglutination may be striking and the direct Coombs' test may be positive.

Anemia Associated with Hemoglobinuria

Certain hemolytic anemias are associated with hemolysis secondary to an intracorpuscular defect. Examination of the urine may reveal oxyhemoglobin and methemoglobin which give the urine a dark brown, almost black appearance. Albuminuria also is noted. These conditions include paroxysmal cold hemoglobinuria, paroxysmal nocturnal hemoglobinuria, transfusion reactions and march hemoglobinemia. These are shown in the appropriate areas of the flow chart.

Other Agents

Hemolytic anemia may be secondary to infectious agents such as Plasmodium, Bartonella bacilliformis, Clostridium perfringens, Streptococcus hemolyticus, Staphylococcus aureus and certain viruses. Physical agents such as heat, ultraviolet light and distilled water also can cause hemolysis. Chemical agents such as sulfonamides, phenylhydrazine, lead, aniline, quinine, mesantoin and nitrofurantoin, to name a few, can cause hemolysis. A history of exposure to one of these agents often can be obtained in obscure hemolytic anemia.

Hereditary Spherocytosis

Hereditary spherocytosis is a condition in which the fundamental abnormality probably is an intrinsic red cell enzyme defect. The cells appear smaller and thicker than normal red cells. The anemia may be mild, moderate or severe. Splenomegaly and reticulocytosis of between 5 and 20 per cent usually are found.

Osmotic fragility always is increased, and the serum bilirubin and fecal urobilinogen are elevated.[17] Spherocytes are seen in the blood smear. The direct Coombs' test is negative.

Hereditary Nonspherocytic Anemia

During recent years a group of nonspherocytic hereditary hemolytic anemias have been identified. In congenital nonspheracytic anemia, the presenting symptoms are anemia, jaundice and splenomegaly. Recent studies indicate the presence of a red cell enzyme abnormality which most commonly is one of three types[3]—abnormal glutathione stability, low glucose-6-phosphate dehydrogenase activity,[11, 9] or a deficit in erythrocyte pyruvate kinase.[12]

Hemoglobinopathies

Abnormal hemoglobins are responsible for hemolytic disease, and the most common of these abnormalities is hemoglobin S which is found in Negroes. This hereditary disease manifests itself as sickle cell trait in the heterozygous form and as sickle cell anemia in the homozygous form. The sickle cell trait is a mild form of the disease and causes few clinical manifestations. Sickle cell anemia is characterized by hemolysis, fever, abdominal pain and jaundice during acute crises. Sickling can be demonstrated *in vitro* by adding reducing agents to the blood. Roentgenographic findings may show a trabecular pattern of the bone and calcification of the spleen. Various other abnormal hemoglobins may be responsible for hemolytic anemia. The majority of abnormal hemoglobins can be detected and identified by electrophoresis.

Thalassemia

In thalassemia the fundamental abnormality is in hemoglobin synthesis which results in thinner, more fragile cells. Thalassemia minor represents the heterozygous state and is characterized by slight anemia, jaundice and splenomegaly. Thalassemia major represents the homozygous state and is characterized by splenomegaly, hepatomegaly and slight jaundice. There may be hypochromasia, poikilocytosis, anisocytosis and target cells in the peripheral blood. Reticulocytes may be moderately increased. Chemical studies detect increased fetal hemoglobin in thalassemia major and electrophoresis will demonstrate a high concentration of hemoglobin as in thalassemia minor.

Normocytic Anemia Without Hemolysis

In this group, anemia is due to decreased erythrocyte production by the bone marrow. Usually the erythrocytes show no morphological abnormality. Bone marrow examination is essential to determine the status of erythrocyte production.

Myelophthisic Anemia

Myelophthisic anemia is a normocytic normochromic anemia resulting from a space-occupying lesion in the bone marrow. A frequent cause is metastatic tumor which may arise in breast, prostate, lung, adrenals, or thyroid. Multiple myeloma, Hodgkin's disease, Gaucher's disease, Niemann-Pick's disease and Schuller-Christian's disease may present a similar picture. Nucleated red cells in the peripheral blood should arouse suspicion of this type of anemia. Diagnosis hinges upon detection of the underlying condition.

Myelofibrosis

Myelofibrosis usually causes normocytic normochromic anemia and is characterized by fibrosis or bony replacement of the marrow which is hypofunctioning. This is accompanied by myeloid metaplasia of the spleen and liver and there may be immature red and white cells in the peripheral blood. Roentgenographic changes show an increased density in the spongy part of the bone. Bone marrow aspirations generally are unsatisfactory necessitating surgical biopsy of the bone for diagnosis. This type of anemia generally is responsive only to blood transfusions.

Simple Chronic Anemia

Simple chronic anemia is a normocytic normochromic anemia associated with infection and chronic systemic disease. The cause may be malignancy, infection, endocrine disorders, or renal disease. Symptoms usually are referable to the disorder present, but anemia may be the only presenting symptom.

Primary Refractory Anemia

Primary refractory anemia, often termed aplastic anemia, presents a picture of thrombocytopenia and granulocytopenia as well as anemia. Destruction of the bone marrow may be caused by physical agents or chemical agents. Onset is insidious, and symptoms do not differ from those generally found in other anemias. Bone marrow aspiration is diagnostic.

Summary

The differential diagnosis of anemia requires a combined clinical-laboratory approach; a flow chart has been constructed to summarize the steps in the diagnostic process. Anemia is a symptom, not a disease and effective treatment requires precise diagnosis.

References

1. Bowman, W. D.: Use of the Prussian Blue Reaction in the Differential Diagnosis of Anemia, Ann. Int. Med. 57:412, 1962.
2. Clement, D. H.: Pitfalls of the Diagnosis and Treatment of Iron Deficiency Anemia in Pediatrics, Pediat. 34:117, 1961.
3. Harris, John W.: The Red Cell, Cambridge, Mass., Harvard University Press, 1963.
4. Kershaw, P. W. & Girwood, R. H.: Some Investigators of Folic Acid Deficiency, Scott. M. J. 9:201, 1964.
5. Kirschenfeld, J. J.: Anemia-Diagnosis and Management, M. Times 92:249, 1964.
6. Menon, M. K., Willmott, M., & Ramswamy, N.: Electrophoretic Pattern of Serum Proteins in Anemia of Pregnancy, J. Obst. & Gynaec. Brit. Emp. 70:57, 1963.
7. Miale, J. B.: J. Lab. & Clin. Med., St. Louis; C. V. Mosby Co., 1962.
8. Miller, E.: A Textbook of Clinical Pathology, Baltimore, Williams and Wilkins Company, 1960.
9. Mohler, D. N. & Crockett, C. L.: Hereditary Hemolytic Disease Secondary to Glucose-6-Phosphate Dehydrogenase Deficiency—Reports on Three Cases With Emphasis on ATP Metabolism, Blood 23:427, 1964.
10. Pitney, W. R.: The Differential Diagnosis of Megaloblastic Anemia, Australian Ann. Med. 12:21, 1963.
11. Shahidi, N. T. & Diamond, L. K.: Enzyme Deficiency in Erythrocytes in Congenital Nonspherocytes Hemolytic Anemia, Pediat. 24:245, 1959.
12. Tanaka, R. R., Valentine, W. N. & Miwa, S.: Pyruvate Kinase Deficient Hereditary Nonspherocytic Hemolytic Anemia, Blood 19:267, 1962.
13. Thirkettle, et al.: Diagnostic Value of Small Oral Doses of Folic Acid in Megaloblastic Anemia, Brit. M. J. 5393:1286, 1964.
14. Townsend, S. R.: Megaloblastic Anemia—An Important Clue to a Precise Diagnosis, Postgrad. Med. 31:79, 1962.
15. Wintrobe, Maxwell M.: Clinical Hematology, Philadelphia, Lea and Febiger, 1961.
16. Yettra, M.: The Therapeutic Response as an Aid to Diagnosis in the Anemia Patient, Gen. Pract. 28-124, 1963.
17. Young, Lawrence E.: Hereditary Spherocytosis, Am. J. Med. 18:486, 1955.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

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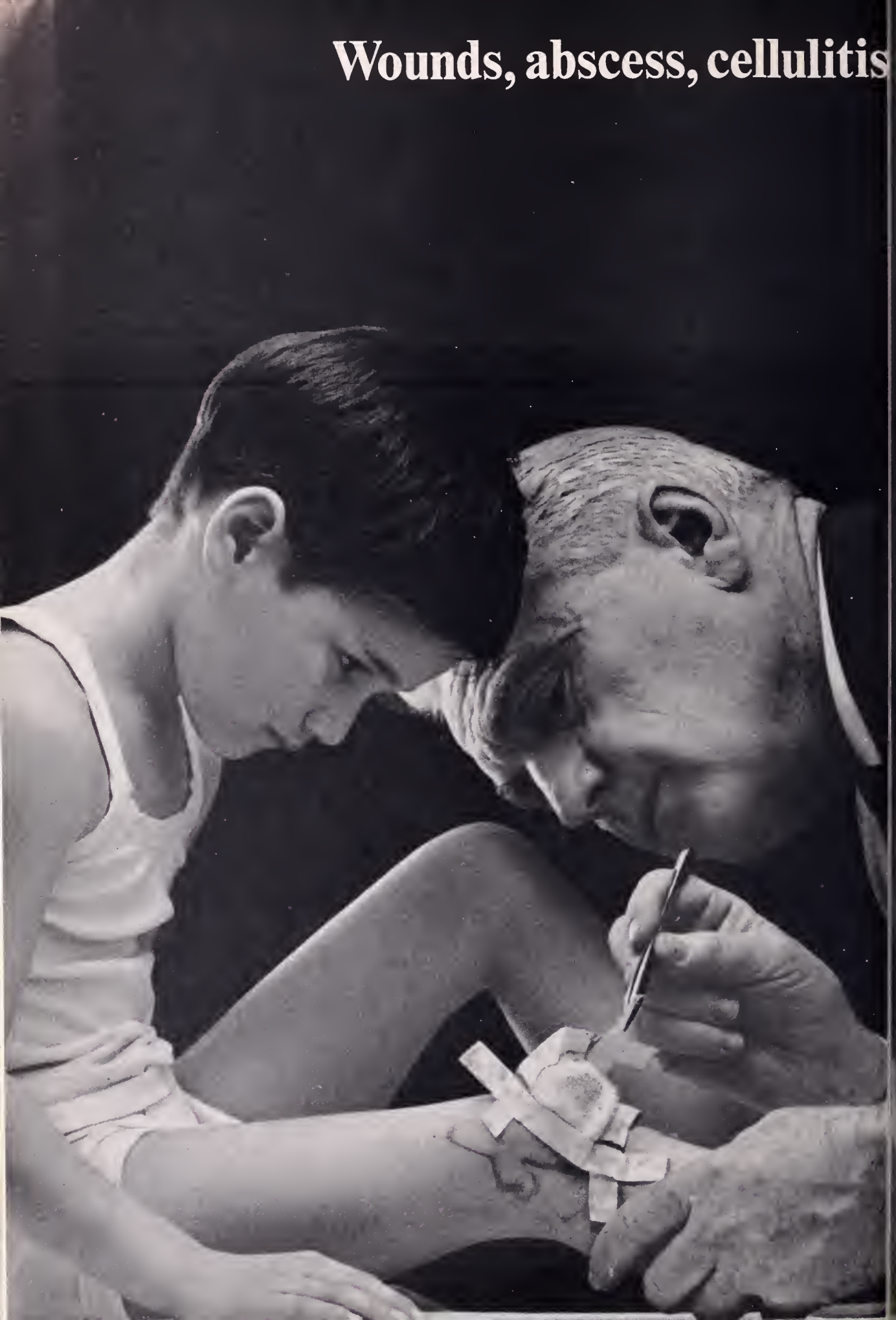
Wounds, abscess, cellulitis



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References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965*, reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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You might also say that all registered nurses aren't alike, either.

Tuberculin Testing (Tine Method) First and Seventh Grade Students Kanawha County, West Virginia, Schools 1965-1967

Peter A. Haley, M. D.

Discovery of a new case of tuberculosis in one of our schools always creates acute concern and, at times, near panic among the parents and relatives of those exposed. For many years, Kanawha County has been known to have a problem with tuberculosis control. For this reason, the School Health Service has conducted an x-ray screening program in our secondary schools for the past 20 years. In spite of finding only an occasional case of tuberculosis (four in 1963-64 and thus being an expensive case-finding procedure), this program *has* found cases and has helped to screen those who have been exposed to these individuals. The pendulum of medical opinion is now swinging away from mass x-ray screening, and this type of program thus becomes suspect. In keeping with a 1966 recommendation of the Kanawha County Community Council's *Community Services Report*, the School Board of Kanawha County, West Virginia, has directed that x-ray screening of students on an annual basis be discontinued. Mass screening by tuberculin testing has been difficult to accomplish for many reasons, not the least of which is parent resistance to another "shot."

In late 1963, a Task Force on Tuberculosis Control in the United States reported to the Surgeon General of the Public Health Service in a publication called *The Future of Tuberculosis Control.* Among many others was the recommendation that all children be tuberculin tested at first entrance to school. Because the risk of tuberculosis in young adults is high, it proposed that all 14-year-olds also be tested. The Public Health Service, in 1965, modified this to read—"fourteen years old or 7th, 8th or 9th grade children."

The Author

- **Peter A. Haley, M. D., Director, Kanawha County Schools Health Service, Charleston, West Virginia.**

During the past few years, a modification of the Mantoux tuberculin test (Tine test) has been accepted for general use. The test is easy to perform, avoiding the many technical difficulties of the Mantoux test, and can be applied easily and quickly in large numbers of children. The results are read in 72 hours, as they are with the standard intradermal test. The degree of specificity of the Tine test is only slightly less than that of the Mantoux. We have employed the former method, and its use and results have proven quite satisfactory.

A review of information released by the Bureau of Tuberculosis Control of the West Virginia State Health Department for 1965 and 1966 reveals the comparative figures as indicated in Table 1.

From these figures, it will be noted that our state and local incidence rates are appreciably higher than the national ones.

It is therefore felt that a pilot study to survey our first and seventh grade children's reaction

TABLE NO. 1

			Prevalence		*Incidence*		*Mortality*	
	Year	*Population*	*Active Cases*	*Rate*	*New Cases*	*Rate*	*Deaths*	*Rate*
USA	1965	185,220,000	330,000	177.6	48,134	24.8	8,170	4.2
	1966	193,795,000	320,000	165.1	49,016	25.3	8,303	4.3
W. Va.	1965	1,840,000	3,209	175.9	518	28.3	81	4.4
	1966	1,815,000	3,176	175.0	776	42.8	100	5.5
Kanawha County	1965	251,187	553	220.2	73	29.1	10	4.0
	1966	248,100	371	149.6	96	38.7	9	3.6

Submitted to the Publication Committee, May 10, 1967.

rate to tuberculin would (1) be in keeping with the Task Force recommendation, (2) supply us with information and data from which we could make comparisons with the experience of other school systems and (3) possibly point to local areas of the county wherein detailed case finding studies should be made. The State Health Department, under the direction of Dr. N. H. Dyer and with the assistance of the Bureau of Tuberculosis Control and of Dr. James H. Walker, Dr. Harold P. Dinsmore and Mrs. Katherine Brown, was most cooperative and agreed to supply the Tine testing material and to do the case finding follow-up of reactors' contacts. The Kanawha-Charleston Health Department, under the direction of Dr. Page H. Seekford, agreed to x-ray all positive reactors.

The project has had the enthusiastic support of the Board of Education; Mr. Walter F. Snyder, Superintendent of Schools; and his associates. Under the direction of Mrs. Hope Stewart, R. N., the program was carried out by our staff of school nurses, working in pairs, as an additional health project.

After a study of the results of the Tine testing of 1965-66 and at the suggestion of Dr. W. L. Cooke and others, it was decided to conduct a similar project in 1966-67 and to combine the findings into a single report.

Mantoux Retest Attempted

It was suggested that all Tine test reactors be retested by the standard intradermal Mantoux method. This was attempted but was found to be impractical. A good percentage of the reactors were followed by their own physicians who took a variety of reactions to further skin testing and in general did not approve, as they felt that an x-ray was required in any event and was a less troublesome method of determining the presence or absence of tuberculosis. In addition, there was marked resistance on the parts of

TABLE NO. 2 SUMMARY OF TESTING BY AGES

Schools	*Ages*	*Enrollment*	*# Tested*	*% Tested*	*# Positive*	*% Positive*
Elementary 1965	5 - 7	5,645	3,009	53.3	69	2.29
Elementary 1966	5 - 7	5,869	4,179	71.1	26	.62
7th Graders 1965	13 - 14	4,952	3,559	71.8	186	5.2
7th Graders 1966	14	4,881	3,758	76.9	122	3.25

TABLE NO. 3 REACTORS BY ATTENDANCE AREAS

Senior High School Area	*School Year*	*Enrollment*	*# Tested*	*% Tested*	*# Positive*	*% Positive*
Cedar Grove	1965-66	372	255	68.5	1	.393
	1966-67	407	264	64.8	3	1.135
Charleston	1965-66	1,449	853	58.7	44	5.16
	1966-67	1,511	1,037	68.6	26	2.53
Dunbar	1965-66	659	422	64.1	20	4.73
	1966-67	687	506	73.6	5	.99
Du Pont	1965-66	709	388	54.7	10	2.58
	1966-67	690	506	73.4	11	2.19
East Bank	1965-66	1,062	693	65.8	11	1.58
	1966-67	985	734	74.5	4	.55
Herbert Hoover	1965-66	829	484	58.4	17	3.53
	1966-67	820	592	72.2	3	.05
Nitro	1965-66	643	468	72.8	11	2.35
	1966-67	721	557	77.4	13	2.31
St. Albans	1965-66	1,356	936	69.0	78	8.34
	1966-67	1,267	1,017	79.4	26	2.55
Sissonville	1965-66	1,066	643	60.4	16	2.45
	1966-67	1,048	743	71.0	26	3.5
South Charleston	1965-66	1,245	510	41.7	40	7.84
	1966-67	1,016	768	75.9	9	1.17
Stonewall Jackson	1965-66	1,277	909	71.2	13	1.43
	1966-67	1,030	809	78.6	23	2.82
George Washington	1965-66	1,110	765	69.0	41	5.36
	1966-67	713	502	70.5	5	.95

parents and students to further testing when the original test was already positive. Some of the reactors were so tested in the clinics operated by the Kanawha-Charleston Health Department, where most were x-rayed, but the number was small and the findings therefore inconclusive.

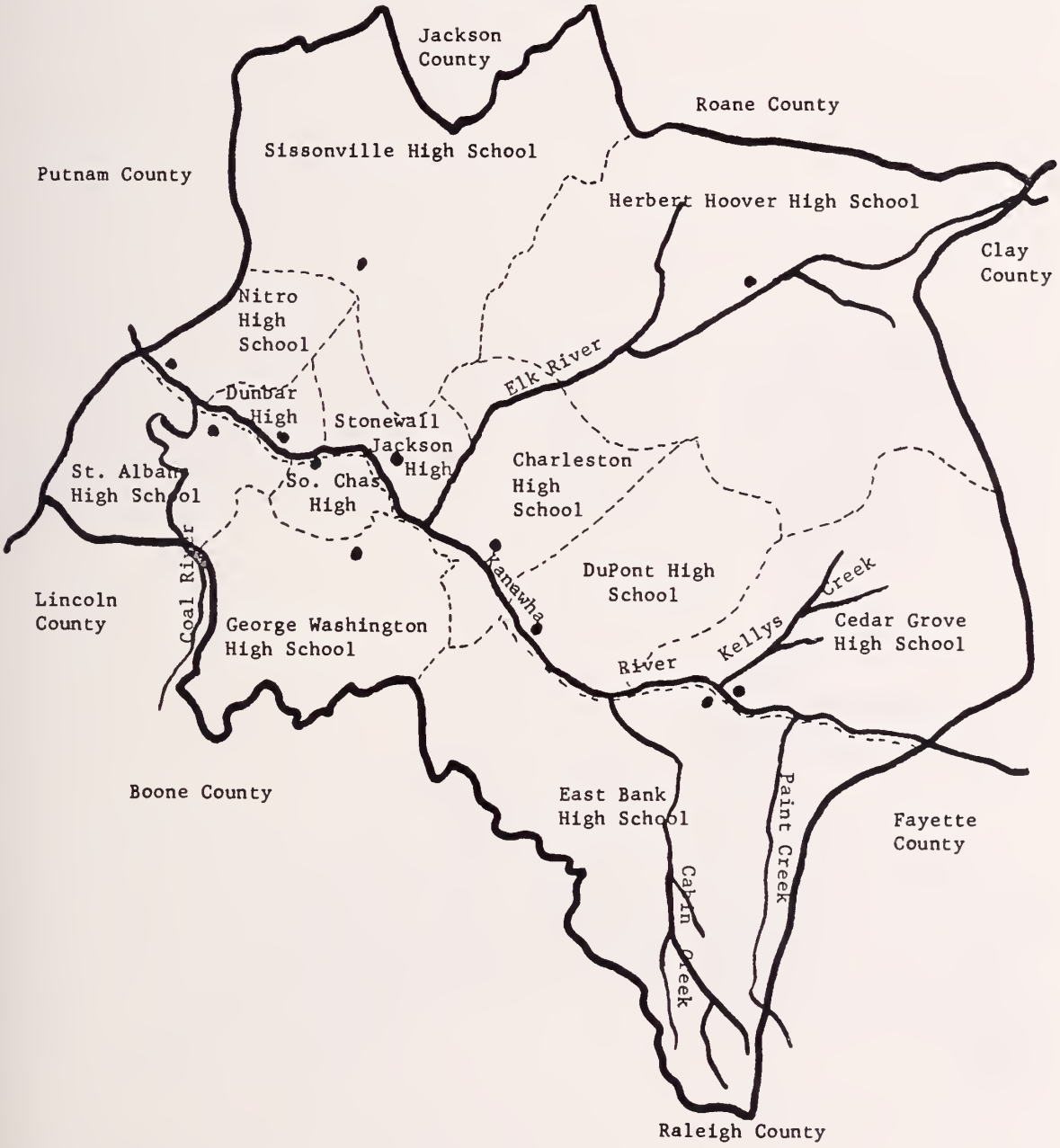
All reactions, regardless of degree, were considered to be positive. In cases of severe reaction, a more intensive follow-up was made. It was found in 1966 that 108 children reacted mildly (1 to 4 mm.), 11 reacted moderately (5 to 9 mm.), and 29 had reactions of 10 mm. or larger.

Chart 1 is a map of Kanawha County showing its relation to neighboring counties, the major streams and the high school attendance areas of the county.

Table 2 is a summary of the testing by ages of children with comparative percentages of participation and positivity of those tested.

Table 3 shows the reactors by high school attendance areas, with the two years of testing

CHART NO. 1
KANAWHA COUNTY HIGH SCHOOL ATTENDANCE AREAS



compared by attendance, acceptance and positive reactors.

Reactor Study Made

A study of tuberculin reactors (Tine method) for school beginners and seventh graders (13-14-year-olds) has been made in the schools of Kanawha County in the school year of 1965-66 with the following observations:

1. Acceptance — Elementary: 53.3 per cent were tested in 1965 as compared with 71.1 per cent in 1966. Secondary: 71.8 per cent were tested in 1965 and 76.9 per cent were tested in 1966.

2. All reactors were x-rayed and no active cases of tuberculosis were found among the 255 positive reactors of 1965 and the 148 positives of 1966.

3. The identity of all positive reactors has been supplied to the Kanawha-Charleston Health Department and to the Bureau of Tuberculosis Control of the State Health Department for follow-up of contacts.

4. One of the real surprises of this survey was to find no reactors in the beginners in the Cabin Creek, Paint Creek and Kelly's Creek areas.

5. The 1965 study revealed 18 positive reactors among the beginners in four elementary schools feeding into South Charleston High School. There were no positives in the 1966 survey of these schools. In 1965, the acceptance in these four schools was 61 per cent, while in 1966, 73.9 per cent were tested.

6. In 1965, six grade schools in the St. Albans attendance area had 21 reactors with 68.2 per cent acceptance. In 1966, those same schools had one positive with an acceptance of 80.8 per cent.

7. Our findings compare unfavorably with the Raleigh County Program (*Raleigh County's Giant Step*) of 1963-64. They found .58 per cent positives in their 6-9-year-olds and .98 per cent positives in the 10-14-year-old children.

Conclusions

1. Statistical studies of Tine test reactors for first and seventh grade students in schools of Kanawha County for the school years 1965 and 1966 are presented.

2. This study revealed that large numbers of children can be efficiently and relatively easily tested for their tuberculin reaction by use of the Tine method.

3. The beginning students of the rural elementary schools have a remarkably low incidence of reaction to tuberculin.

4. The concentration of reactors found in the 1965 study in the St. Albans-South Charleston schools was not borne out in the study of 1966.

5. The acceptance of this type of program can be improved significantly by a better understanding of the objectives by the children, parents, and teachers involved (acceptance 1965—61.9 per cent and 1966—73.8 per cent).

Note.—A detailed break-down of the two-year study by grade and junior high schools is available and will be supplied to those requesting it.

The Cost of No Cancer Cure

If any group of people, whether it be industry or government, ever started directing all the research, research would be dead. It may sound as if there is some duplication, but it is duplication of objective, rather than duplication of work. If, for example, three companies are working on the solution of the cancer problem, it is likely that each will be using a different approach to the solution. It is true that the research will cost three times as much, but there will be three times as many chances to solve the problem. I'd rather pass on to the consumer the cost of the cancer cure than to pass on to the consumer the cost of no cancer cure.—Dr. Thomas F. Carney in broadcast over radio station WBBM, Chicago.

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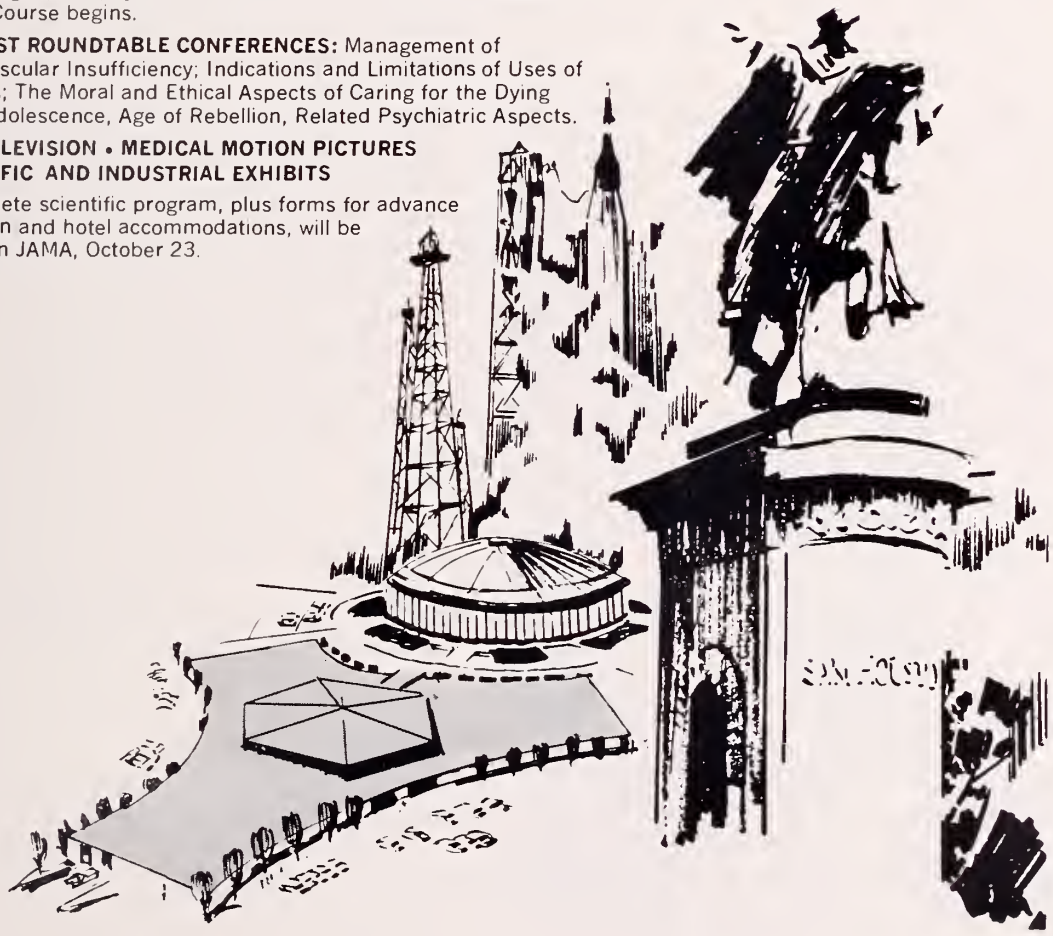

A message from . . .

The President

NEEDED: FULL SUPPORT AND COOPERATION

THE Annual Meeting was quite a success this year. For once the operation of the entire meeting went smoothly and without a hitch. All the invited participants were able to come, make their speeches and talks and substitutes were not required.

The quality of the scientific presentations was, I thought, top notch—both in content and in delivery. I cannot speak for all the section meetings, but those I attended fully complemented the general scientific sessions. Attendance also was excellent—thanks no doubt to the somewhat inclement weather which sort of made a captive audience for the meetings. It was nice, however, to see the crowds attending the scientific sessions for once.

One of the most thought-provoking presentations during the annual session was the Deans' Panel on Medical Education celebrating Doctor Van Liere's Day. In this discussion was presented old and new ideas in medical education on the premedical, medical, postmedical, graduate and postgraduate levels. I felt that this was particularly auspicious in view of the activities currently being undertaken by our own Committee on Medical Education and Hospitals under the direction of Dr. Pat A. Tuckwiller. The goal of this Committee is the coordination of postgraduate medical education for physicians practicing in West Virginia. The members are working closely with the regional medical programs established under Public Law 89-239 and currently under the direction of Doctor Wilbar of Morgantown. Also, with the West Virginia University School of Medicine under the direction of Drs. Clark K. Sleeth and David Z. Morgan, the West Virginia Heart Association under Dr. Herbert E. Warden, the Comprehensive Health Planning Program (PL 89-749) under Dr. Richard Slavin of the Governor's Office, and the Appalachian Regional Development Act of 1965 (PL 89-4) under Dr. Daniel Hale in the southern counties in West Virginia.

This will require a tremendous amount of work and cooperation on the part of the State Medical Association. I wish this Committee a brilliant success and I ask all members of the West Virginia State Medical Association to furnish Doctor Tuckwiller and his Committee all possible cooperation and support.

Richard V. Lynch, Jr., M.D.

RICHARD V. LYNCH, JR., M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

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EDITORIALS

THE NEW PRESIDENT

Members of the West Virginia State Medical Association, following a year-long observance of the founding of the Association 100 years ago, now look forward to the years ahead with a renewed pledge to continue to provide dedicated service to the citizens of West Virginia. Leading the Association into its second 100 years will be Dr. Richard V. Lynch, Jr., of Clarksburg, who was installed as President at the close of the Centennial Meeting at The Greenbrier.

Doctor Lynch, who has practiced his specialty of internal medicine in Clarksburg since 1949, has been identified closely with the affairs of the Association for many years. He has given generously of his time as a member of important committees and worked his way up through the ranks to the office of President.

In his community, Doctor Lynch devotes much time to civic and service organizations. He was elected a member of the Clarksburg City Council in 1963 and was reelected for a four-year term in June of this year. He continuously supports projects for the betterment of the community.

Doctor Lynch was born in Clarksburg, the son of the late Dr. Richard V. and Mary Romine Lynch. He attended Victory High School in Clarksburg and Culver Military Academy in Culver, Indiana, and was graduated from West Virginia University. He received his M. D. degree in 1943 from the University of Pennsylvania

Richard V. Lynch, Jr., M. D.

School of Medicine. He interned at Presbyterian Hospital in Philadelphia and served a residency in internal medicine at Abington Memorial Hospital in Abington, Pennsylvania.

During World War II, Doctor Lynch served as a Captain in the Medical Corps of the United States Army and presently is serving as a Lieutenant Colonel in the Medical Corps of the United States Air Force Reserve.

He is a Past President of the Harrison County Medical Society and served four years as a member of the Council of the State Medical Association. He served as Vice President and President Elect before being elevated to the Presidency of the Association.

Doctor Lynch is a member of the American Medical Association, American College of Physicians and the American College of Chest Physicians. He is a Past President of the Potomac Chapter of the American College of Chest Physicians, the West Virginia Tuberculosis and Health Association, the West Virginia Thoracic Society, and the West Virginia Diabetes Association.

Doctor Lynch is married to the former Mary M. Horner and they have two sons, Richard V. Lynch, III, who is presently engaged in research in bio-physics at the University of Pittsburgh; and David, a mechanical engineering student at Carnegie Tech.

In his inaugural address, Doctor Lynch made it clear that this will be an extremely busy and productive year for the Association. He intends to implement the recommendations of the House of Delegates and Council and we know he can rely upon the members of the Association to give him a helping hand. He has all the qualities of a good leader and we wish him well in the busy months ahead.

"The hospitality extended to us by you and so many members of the Medical Association and its Auxiliary will long be remembered. I can only say that if you should ever want us back, you have only to ask."

Those were the sentiments expressed in a letter received from one of the honor guests following the Centennial Meeting at The Greenbrier. All of the speakers expressed sincere appreciation for the wonderful hospitality, and the members of the reception committee and their wives deserve a great deal of thanks.

We also owe thanks to Dr. Ray S. Greco and the members of the Program Committee, as well as Dr. J. P. McMullen who was in charge of the Centennial Activities Committee.

Dr. Richard E. Flood's term of office came to an end at the final session of the House of Delegates. He guided us through the Centennial Year masterfully and handled the added responsibilities without difficulty. Certainly few other men ever devoted more time and energy in discharging the duties of President. We look forward to his continued leadership in the role as Chairman of the Council during the coming year.

The Centennial Meeting will be remembered for years to come by the more than 750 physicians, wives, exhibitors and guests who were at The Greenbrier. For the first time in 12 years, the weatherman treated us to daily showers but even this failed to dampen the spirit of the meeting. Actually, the wet grounds brought about unusually good attendance at the scientific and business meetings.

The 100th is history and we hope you will plan to be with us for the 101st at The Greenbrier next August.

DEPARTMENT OF PHYSIOLOGY AND BIOPHYSICS

During the past year the physiology department at West Virginia University Medical Center has been given a new name—The Department of Physiology and Biophysics. With the new nomenclature there are occurring rather fundamental departures in staffing the expanded department. The changes reflect both a re-emphasis of the origins of physiology and a re-orientation of this medical basic science to cope with present trends of increasing quantification of biological and medical knowledge.

From its inception the science of physiology was grounded in and supported by the older disciplines of physics and mathematics. Indeed, the 19th century physician-physicist, Ludwig von Helmholtz, who is often referred to as the father of modern physiology, saw the study of the function of the body as a natural extension of the simpler laws that govern inanimate relations of the universe. His principle of the *conservation of energy* remains a fundamental tenet of physics and medical science. For example, it is the basis for the use of oxygen consumption in the calculation of pulmonary blood flow by the Fick method and for the evaluation of renal function by clearance measurements. The famous Poiseuille formula for determining blood flow, and the unit of viscosity (the *poise*), named in honor of the French physician who made the pioneer measurements (ca. 1820), represents a scientific "collaboration" ranging over three centuries of effort. Our current understanding of the manner in which blood flows,

stems from the basic equations of: (1) Sir Isaac Newton, the 17th century English physicist, which evaluate the viscosity or inner friction of a fluid, (2) Daniel Bernoulli, 18th century Swiss mathematician, which characterize the dynamic events, e.g., velocity, lateral pressure and energy losses of a moving column of fluid, and (3) Poiseuille.

These early giants, who contributed to quantitative physiology, have been followed by whole generations of scientists who, at times, seem to speak a language of their own which is directed primarily to their peers. The process of specialization and subspecialization has created problems of communication for the medical basic sciences comparable to those of clinical medicine. Biochemistry, an early offspring from the parent discipline of physiology, increasingly speaks in terms of enzyme-substrate reactions, enzyme kinetics, chromosome dynamics and the DNA double helix. The Cell Biologist refers, for example, to molecular receptor sites, inherited "biochemical" diseases, and RNA messenger. The Molecular Biophysicist calculates electrochemical potentials from transmembrane ion exchange, active and passive transport across cell membranes, and molecular diffraction patterns from x-ray crystallography. However, each of these offspring from physiology use the general notations of the physicist and the physical chemist, e.g., millimols, nanomols, coulombs, dynes, ergs, et cetera; and present their concepts by graphical and mathematical means. Most are familiar with the concepts of coding, decoding and encoding.

All of these analytic fundamentals must be interpreted by some comprehensive method if they are to be generally useful to the student of the medical sciences in his future role as a physician. The most promising method is the Analysis of Systems which utilizes the language of control theory, developed initially by the communications engineer, to characterize the informational content of a given set of reactions or the flow of information from one set of reactions (i.e., system) to another. In this way the medical basic scientist can, at least, collate the existing knowledge into a meaningful whole; and in concert with the clinician, identify the features of importance to patient care. The new breed of teacher—the General Biophysicist, or Quantitative Physiologist, if you will—is bringing this approach to medical physiology at the West Virginia University Medical Center.—*Guest Editorial by Michael F. Wilson, M. D., Professor and Chairman of the Department of Physiology and Biophysics, West Virginia University School of Medicine.*

PROFESSIONAL COURTESY

The custom of professional courtesy embodies the ancient tradition of fraternalism among physicians in the art which they share, and their mutual concern to apply their learning for the benefit of one another as well as their patients. The Judicial Council reaffirms and endorses the principle of professional courtesy as a noble tradition that is adaptable to the changing scene of medical practice.

Professional courtesy is not a rule of conduct that is to be enforced under threat of penalty of any kind. It is the individual responsibility of the physician to determine for himself and within his own conscience to whom and the extent to which he shall allow a discount from his usual and customary fees for the professional services he renders, and to whom he shall render such services without charge as professional courtesy.

The following guidelines are offered as suggestions to aid physicians in resolving questions related to professional courtesy.

1. Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physician need not be embarrassed to accept a fee for his services.

2. Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his dependents have insurance providing for benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional ethical practice of physicians caring for the medical needs of colleagues and their dependents without charge.

3. In the situation where a physician is called upon to render services to other physicians or their immediate families with such frequency as to involve a significant proportion of his professional time, or in cases of long-term extended treatment, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.

4. Professional courtesy should always be extended without qualification to the physician in financial hardship, and members of his immediate family who are dependent upon him.—*Adopted by the Judicial Council, American Medical Association, June* 17, 1967.

GENERAL NEWS

Dr. R. V. Lynch Takes Oath As Association President

Dr. Richard V. Lynch, Jr., of Clarksburg, was installed as President of the West Virginia State Medical Association during the Centennial Meeting at The Greenbrier in White Sulphur Springs, August 24-26.

Dr. Richard V. Lynch, Jr., of Clarksburg (left) takes the oath of office as President of the State Medical Association. Administering the oath is Dr. Richard E. Flood of Weirton, retiring President who automatically became Chairman of the Council for one year.

Doctor Lynch's inauguration, to succeed Dr. Richard E. Flood of Weirton, was one of the highlights of the second and final session of the Association's House of Delegates on Saturday afternoon, August 26. Following the House session, there was a reception honoring Doctors Lynch and Flood and other officers of the Association.

Doctor Flood will serve as Chairman of the Council for one year.

Doctor Corbitt President Elect

Dr. Richard W. Corbitt of Parkersburg, Vice President for the past year, was elevated to the office of President Elect. He will be installed as President at the 101st Annual Meeting of the Association, which will be held at The Greenbrier next August 22-24.

Dr. Maynard P. Pride of Morgantown, a member of the Council for the last four years, was named Vice President. Dr. Kenneth G. MacDonald of Charleston was elected to his third term as Treasurer.

Council Enlarged

The House gave final approval to a change in the by-laws which realigns the Association's Councilor Districts. Heretofore, the Council has consisted of 14 members, including the Chairman, one at-large member, and two members from each of six districts.

Under the change, there will be 14 districts, each represented by one councilor, except for the Eleventh District (Kanawha, Putnam, Boone and Clay counties), which will have two councilors. The amendment has the effect of enlarging the Council from 14 to 17 members.

The new Council will consist of the following members of the Association:

Dr. Richard E. Flood of Weirton, Chairman; Dr. Seigle W. Parks of Charleston, Councilor-at-Large; Dr. Harry S. Weeks, Jr., of Wheeling, elected to a two-year term from the First District (Hancock, Brooke, Ohio and Marshall Counties); Dr. G. Thomas Evans of Fairmont, re-elected to a one-year term from the Second District (Marion, Taylor and Wetzel Counties); Dr. George A. Curry of Morgantown, elected to a two-year term from the Third District (Monongalia and Preston Counties), to succeed Dr. Maynard P. Pride, who was elected Vice President.

Dr. S. Elizabeth McFetridge of Shepherdstown, re-elected to a one-year term from the Fourth District (Morgan, Berkeley and Jefferson Counties); Dr. R. W. Bess, Jr., of Piedmont, elected to a two-year term from the Fifth District (Grant, Mineral, Hardy, Hampshire and Pendleton Counties); Dr. A. Kyle Bush of Philippi, elected to a one-year term from the Sixth District (Barbour, Randolph, Tucker and Pocahontas Counties); Dr. Andrew J. Weaver of Clarksburg, re-elected to a two-year term from the Seventh District (Harrison, Tyler and Doddridge Counties).

Dr. William E. Gilmore of Parkersburg, re-elected to a one-year term from the Eighth District (Wood, Jackson, Pleasants, Ritchie, Wirt and Roane Counties); Dr. Robert L. Chamberlain of Buckhannon, re-elected to a two-year term from the Ninth District (Lewis, Upshur, Gilmer, Calhoun, Braxton, Webster and Nicholas Counties); Dr. William L. Neal of Huntington, elected to a one-year term from the Tenth District (Cabell, Mason, Wayne and Lincoln Counties), to succeed Dr. I. Ewen Taylor of Huntington, who was not eligible for re-election.

Dr. George R. Callender, Jr., of Charleston, re-elected to a two-year term from the Eleventh District (Kanawha, Putnam, Boone and Clay Counties); Dr. Joseph A. Smith of Dunbar, elected to a one-year

term from the Eleventh District; Dr. Worthy W. McKinney of Beckley, elected to a one-year term from the Twelfth District (Raleigh, Fayette and Greenbrier Counties); Dr. W. Hampton St. Clair, Jr., of Bluefield, elected to a two-year term from the Thirteenth District (Mercer, Summers and Monroe Counties), to succeed Dr. Buford McNeer of Hinton, who was not eligible for re-election; and Dr. A. J. Villani of Welch, re-elected to a one-year term from the Fourteenth District (McDowell, Wyoming, Mingo and Logan Counties).

Doctor Holroyd Re-Elected

Dr. Frank J. Holroyd of Princeton was re-elected to a two-year term as a Delegate to the American Medical Association. Re-elected Alternate Delegate was Dr. Thomas G. Reed of Charleston.

Holdover Delegate and Alternate are Dr. C. A. Hoffman of Huntington and Dr. D. E. Greeneltch of Wheeling, respectively.

Doctor Lynch Clarksburg Native

Doctor Lynch, the new President, was born in Clarksburg, where he is now engaged in the practice of internal medicine.

He attended Victory High School in Clarksburg and Culver Military Academy in Indiana, and later received an A.B. degree from West Virginia University. He received his M.D. degree from the University of Pennsylvania Medical School.

For many years, Doctor Lynch has taken an active part in the affairs of his community and his profession. Last June, he was elected to his second four-year term as a member of the Clarksburg City Council.

Three members of the Program Committee, which planned the scientific program for the 100th Annual Meeting, are pictured as they awaited the formal opening of the convention. They are (left to right): Dr. Ray S. Greco of Weirton, Chairman; Dr. Joseph Romino of Fairmont; and Dr. Robert Greco of Morgantown. Absent when picture was taken was Dr. Richard W. Corbitt of Parkersburg.

During World War II, he served as a Captain in the Medical Corps of the United States Army and presently holds the rank of Lieutenant Colonel in the United States Air Force Reserve.

A Past President of the Harrison County Medical Society, Doctor Lynch served on the Council of the State Medical Association for four years. He was

New officers of the State Medical Association pause for a moment after their installation to admire a presidential plaque presented to Dr. Richard E. Flood of Weirton, the retiring President. Pictured are (left to right): Dr. Richard W. Corbitt of Parkersburg, President Elect; Dr. Richard V. Lynch, Jr., of Clarksburg, President; Dr. Seigle W. Parks of Charleston, now Councilor-at-Large; Dr. Flood, now Chairman of the Council; Dr. Maynard P. Pride of Morgantown, Vice President; and Dr. Kenneth G. MacDonald of Charleston, who was elected to his third term as Treasurer.

Newly-elected members of the Council of the West Virginia State Medical Association are shown with Dr. Richard E. Flood of Weirton (seated second from right), who will head the Council during the coming year. Shown are (seated): Dr. William L. Neal of Huntington, Dr. George A. Curry of Morgantown, Doctor Flood, and Dr. Worthy W. McKinney of Beckley. Standing are Dr. Joseph A. Smith of Dunbar, Dr. W. Hampton St. Clair, Jr., of Bluefield, and Dr. Robert W. Bess, Jr., of Piedmont. Absent when picture was made was Dr. A. Kyle Bush of Philippi.

elected Vice President of the Association in 1965 and President Elect one year later.

Doctor Lynch is a member of the American Medical Association, the American College of Physicians and the American College of Chest Physicians. He has been a Director, Vice President and President of the West Virginia Tuberculosis and Health Association; Secretary and President of the West Virginia Thoracic Society; Director, Secretary and President of the West Virginia Diabetes Association; Director of the West Virginia Heart Association; and President of the Potomac Chapter of the American College of Chest Physicians.

Doctor Lynch and his wife, the former Mary M. Horner, have two sons: Richard V. Lynch, III, who is engaged in research in biophysics at the University of Pittsburgh; and David, a mechanical engineering student at Carnegie Tech.

The President Elect

Doctor Corbitt, the President Elect, was born in Waverly and now practices urology in Parkersburg. He attended West Virginia University and received his M. D. degree from the University of Maryland College of Medicine in 1939.

During World War II, Doctor Corbitt was a Lieutenant in the Medical Corps of the United States Navy and served as Chief of Urology at military hospitals in Saipan, Hawaii and Parris Island, South Carolina.

Doctor Corbitt is a Fellow of the American College of Surgeons and served on the Council of the State Medical Association for several years. He was named Vice President in 1966.

In his community, Doctor Corbitt has served as President of the Parkersburg Chamber of Commerce and Coroner of Wood County. An avid high school athletics fan, he has headed the State Medical Association's Committee on the Medical Aspects of Sports for several years and in recognition of his devotion to high school sports, the West Virginia Coaches Association named him an "honorary coach" two years ago.

Doctor Corbitt has served as Chairman of the West Virginia Commission on Postmortem Examinations since the Legislature created it in 1963.

Resolutions Committee

The Resolutions Committee met on Thursday afternoon, and with only one resolution up for consideration, the agenda was the lightest in many years. The report of this Committee appears elsewhere in this issue of *The Journal.*

Honor Guests

Three honor guests addressed the Association during the three-day meeting.

Dr. Milford O. Rouse of Dallas, Texas, President of the American Medical Association, spoke at the first session of the House of Delegates on Wednesday after-

Dr. Milford O. Rouse (left photo), President of the American Medical Association, studies the outline of the remarks he was about to make at the first session of the House of Delegates. Right photo shows six speakers who presented papers at the 10th Annual Meeting of the West Virginia State Society of Allergy, and two of the Society's officers. Seated are: Dr. Irvin Caplin of Indianapolis, Indiana; Dr. Howard G. Rapaport of New York City, President of the American College of Allergists; Dr. Philip Blank of Pittsburgh; and Dr. Joseph A. Fries of New Hyde Park, New York. Standing: Dr. A. Harvey Neidorff of Altoona, Pennsylvania; Dr. Bernard A. Berman of Boston, Massachusetts; Dr. Robert Mutch of Fairmont, President of the State Society of Allergy; and Dr. Merle S. Seherr, Secretary-Treasurer of the Society.

noon, August 23. He also participated in a special Medicine and Religion Program the following day.

Dr. William B. Walsh of Washington, D. C., Founder, President and Medical Director of Project HOPE, spoke at opening exercises on Thursday morning, August 24.

Dr. Perry E. Gresham, President of Bethany College, was the after-dinner speaker for the Centennial Banquet which was held on Friday evening, August 25.

AMPAC Chairman Speaks

The first session of the House of Delegates also featured an address by Dr. Blair J. Henningsgaard of Astoria, Oregon, Chairman of the Board of AMPAC.

Amendments to Constitution and By-Laws

The House of Delegates approved several amendments to the Constitution and By-Laws which had been approved by the Constitution and By-Laws Committee. The amendments appear elsewhere in this issue of *The Journal.*

Dr. James S. Klumpp of Huntington was Chairman of the Committee, and other members were Drs. J. C. Huffman of Buckhannon, Kenneth G. MacDonald of Charleston, L. J. Pace of Princeton, and Jack Leckie of Huntington.

Presidential Address

Doctor Flood's Presidential Address, entitled "The State of the Association", was presented at the second session of the House of Delegates on Saturday afternoon. The text of his remarks appears elsewhere in this issue of *The Journal.*

Doctor Sleeth Presented AMA-ERF Check

Another feature of the final House session was the presentation of a check in the amount of $16,587.60 to Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine. The check represented the year's contributions by West Virginia physicians and their wives to the School of Medicine through AMA-ERF.

The three honor guests at the 100th Annual Meeting engage in some conversation during an interlude preceding the Past Presidents' Luncheon. They are (left to right): Dr. Perry E. Gresham, President of Bethany College; Dr. Milford O. Rouse of Dallas, Texas, President of the American Medical Association; and Dr. William B. Walsh of Washington, D. C., Founder, Medical Director and President of Project HOPE.

Centennial Events

Three special Centennial events drew large crowds during the 100th Annual Meeting.

More than 300 persons attended the Centennial Reception, Banquet and Ball on Friday evening.

A large number of physicians, their wives and guests attended a special Medicine and Religion Program on Thursday afternoon. The Rev. Dr. Paul B. McCleave of Chicago, Director of the American Medical Association's Department of Medicine and Religion, moderated a discussion of "The Physician's Dilemma in the World of Changing Attitudes Toward Morals." Panelists included Dr. Milford O. Rouse of Dallas, Texas, President of the American Medical Association, and the Most Rev. Joseph B. Brunini, Apostolic Administrator of the Catholic Diocese of Natchez-Jackson in Mississippi.

Likewise well-attended was the "Van Liere—University Day Program" on Saturday morning, conducted

Mr. Robert L. Coons discusses the American Medical Association's Medicine and Religion Program (left photo) with Dr. N. H. Dyer, State Health Director (second from left); and Dr. and Mrs. William A. Sodeman of Philadelphia. Doctor Sodeman recently retired as Dean of Jefferson Medical College. In right photograph, Dr. Thomas L. Harris of Parkersburg (second from left) chats with two visiting speakers and a guest. At left is Dr. John Parks of Washington, Dean of the George Washington University School of Medicine. At right is Dr. Brian Blades, Chairman of the Department of Surgery at George Washington. The boy is Charlie, Doctor Blades' grandson.

in honor of Dr. Edward J. Van Liere, Dean Emeritus of the West Virginia University School of Medicine. Dr. Clark K. Sleeth, the present Dean of the WVU School of Medicine, moderated a discussion of "Medical Education—Past, Current and Future" in which deans of six other medical schools in neighboring states also participated.

101st Meeting at The Greenbrier

The Council voted to conduct the 101st Annual Meeting of the West Virginia State Medical Association at The Greenbrier, August 22-24, 1968.

The total registered attendance for the 100th Annual Meeting was 768, which compares with 715 in 1966 and 709 in 1965. The physician registration was 411, compared with 408 last year. The Auxiliary registration was 233, compared with 211 in 1966, and the total registration of exhibitors and other guests was 124.

Cleveland Clinic Foundation Lists PG Courses

The Cleveland Clinic Educational Foundation has listed the following courses for the remainder of 1967-68:

October 18—"Update 1967—Selected Topics in Nursing."

November 8-9—"Problems in Pelvic Surgery."

November 15-16—"Pain: Neurological and Neurosurgical Aspects."

December 6-7—"Postgraduate Course in Ophthalmology."

January 17-18—"Treatment of Surgical Emergencies."

January 31-February 1—"General Practice."

February 28-29—"Recent Advances in Pediatrics."

March 6-7—"Controversies in Urology."

March 20-21—"Current Management of Renal Disease."

March 27-28—"Medical Progress and Its Relationship to Dentistry."

April 3-4—"Fundamental Principles of Anesthetic Technic."

April 17-18—"Psychiatry in General Practice."

April 24-25—"Laboratory Aspects of Hematology."

Additional information and detailed programs may be obtained by writing to: Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

McGuire Lecture Series On Gastroenterology

The McGuire Lecture Series on Gastroenterology will be presented at the Medical College of Virginia in Richmond, November 9-10.

Several prominent clinicians will join Dr. Franz J. Ingelfinger, McGuire Lecturer, in presenting the program.

Additional information may be obtained by writing to Dr. Charles M. Caravati, Director of Continuing Education, Medical College of Virginia, Richmond, Virginia.

Professional Nursing Students Awarded Scholarships

The Professional Nursing Education Trust, an instrument of the West Virginia Nurses Association, awarded 10 scholarships in September.

Five new grants were made and five others were renewed, according to H. P. Porter of Charleston, Chairman of the Trust Fund, and Mrs. Josephine Fultz of Clarksburg, President of the Association.

New grants were awarded to the following students:

Freida Diana Baldwin of Charleston, a second-year student at the Morris Harvey College Department of Nursing in Charleston; Sandra Catherine Behrens of Triadelphia, a senior, and Stephanie Ann Gordon of Weirton, a junior, both enrolled at Wheeling Hospital School of Nursing; and Linda Susan Ellis of Powellton, a freshman, and Sandra Kay Workman of Verdunville, a senior, both students at Charleston General Hospital School of Nursing.

Scholarships were renewed for the following:

Anita Burgess, a senior, and Patricia Moore, a junior, both of Alderson-Broaddus College Department of Nursing; Phyllis Harrison, a senior at St. Mary's Hospital School of Nursing in Clarksburg; Mrs. Juanita Lewis, a senior nursing student at Morris Harvey College; and Sharon McCombs, a senior at Wheeling Hospital School of Nursing.

About $20,000 in scholarships has been awarded to 38 students to pursue their nursing education since the Trust Fund was created in 1958.

Salem College Will Train Medical Secretaries

Salem College will offer a curriculum in medical secretarial science at its Clarksburg branch for the first time this semester, Mrs. Anne West, Head of the Department of Secretarial Science, has announced.

Mrs. West said the two-year course will train students for secretarial work in doctors' offices, hospitals, health centers, public health facilities and the like.

The first year's work will stress secretarial skills. During the second year, emphasis will be on medical secretarial training, and arrangements will be made for in-service training in hospitals and doctors' offices.

Merger of B-R-T and Taylor Medical Societies Approved

The House of Delegates of the West Virginia State Medical Association unanimously approved the merger of the Barbour-Randolph-Tucker Medical Society and the Taylor County Medical Society.

The new organization will be named the Tygart Valley Medical Society and a charter will be issued following the organizational meeting and election of officers.

Seven medical school deans (top photo) presented a special "Van Liere-University Day Program" on Saturday morning during the Annual Meeting in honor of Dr. Edward J. Van Liere, Dean Emeritus of the WVU School of Medicine (seated second from right). Participants were (seated): Drs. William A. Sodeman, Jefferson Medical College; Charles A. Doan, Ohio State University; and Kinloch Nelson, Medical College of Virginia. Standing: Drs. Clark K. Sleeth, WVU; William S. Stone, University of Maryland; John Parks, George Washington University; and Kenneth Crispell, University of Virginia.

Center photograph shows six physicians who were presented awards by the Auxiliary for their assistance in the AMA-ERF project. Pictured are Dr. M. Bruce Martin of Huntington; Mrs. Martin; Dr. Wilson P. Smith of Huntington; Dr. Seigle W. Parks of Charleston; Dr. Richard E. Flood of Weirton; Dr. Albert C. Esposito of Huntington; Dr. Myer Bogarad of Weirton; and Mrs. Smith.

In bottom photo, Doctor Flood (left) jokes with some visiting State Presidents. They are: Drs. R. E. Pennington, Kentucky; Newton DuPuy, Illinois; R. D. Bauer, Maryland; R. E. Howard, Ohio; and J. E. McClenahan, Pennsylvania.

Hospital Problems Conference In Florida

A postgraduate conference entitled "Today's Hospital Problems: An Interdisciplinary Approach" will be held at Redington Beach, Florida, October 26-28.

The course is for chiefs of staff, hospital directors and governing personnel. Sponsors are the Mound Park Hospital Foundation of St. Petersburg, Florida, and the Division of Continuing Education, J. Hillis Miller Health Center, University of Florida.

Registration fee is $75, and the American Academy of General Practice has accredited the course for 18 hours.

Additional information may be obtained by writing to the Department of Postgraduate Education, Mound Park Hospital Foundation, Inc., St. Petersburg, Florida 33701.

CAMERA HIGHLIGHTS

100th Annual Meeting

WEST VIRGINIA STATE MEDICAL ASSOCIATION

The Greenbrier

August 24-26

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These four gentlemen—two physicians and two clergymen—took part in a special medicine and religion program during the 100th Annual Meeting. Shown (from left to right) are: Dr. Tracy N. Spencer, Jr., of South Charleston, Chairman of the Association's Committee on Medicine and Religion; Dr. Milford O. Rouse of Dallas, Texas, President of the American Medical Association; Catholic Bishop Joseph B. Brunini of Jackson, Mississippi; and the Rev. Dr. Paul B. McCleave of Chicago, Director of the AMA's Department of Medicine and Religion.

Partnership for Health Funds Given to State

Gov. Hulett C. Smith has announced West Virginia's first federal grant under the new Partnership for Health Program.

The grant will fund a $20,000 project for short-term training in health planning by the Governor's Office. The program provides grants to states for comprehensive health planning, area-wide comprehensive health planning, public health service and health services development projects.

Partnership for Health calls for participation at the state and local levels of all segments of the health community, including consumers of health services. Under Public Law 89-749, West Virginia and local communities will determine the priority of health needs in order to gather the necessary resources, manpower and facilities to meet existing and potential health problems.

Diabetes Association Meeting At Oglebay Park

The West Virginia Diabetes Association will have its annual meeting on Sunday, October 1, at Oglebay Park in Wheeling.

The scientific session will include a panel discussion of diabetic complications. Members of the faculty of the West Virginia University School of Medicine will participate.

A business meeting will follow.

Nutrition Booklet for Patients

Your patients' misconceptions about nutrition can be easily rectified with answers from a new book soon to be published by the AMA.

"Let' Talk About Food" covers such main topics as nutritional definitions, adequate diet, weight control, foods and their composition, effects of foods on the body, food preparation, food preservation and storage, and food additives.

This informative booklet, designed for the layman, is written in question and answer form. It contains understandable, but medically precise answers to such questions as: "Do certain cuts and varieties of meat contain more protein, fat, vitamins and minerals than others?" "Is it true that margarine has fewer calories than butter?" "What is the composition of condensed milk?" If milk is disliked, is it possible to obtain a balanced diet without it?"

Camera Highlights

(See Pages 368-369)

(1) Dr. Milford O. Rouse of Dallas, Texas, President of the American Medical Association, (right) talks with Dr. Frank J. Holroyd of Princeton before the opening of the pre-convention meeting of the Council.

(2) Part of the receiving line at the reception honoring officers of the Association on Saturday evening. At extreme right is Dr. Maynard P. Pride of Morgantown, the newly elected Vice President.

(3) Dr. Warren D. Elliott (left) and Dr. Forest A. Cornwell, both of Beckley, await the opening of a session of the House of Delegates.

(4) Drs. R. L. Chamberlain of Buckhannon (left) and William E. Gilmore of Parkersburg, both members of the Council, find time for some conversation between registering and the pre-convention Council meeting.

(5) These four delegates from Kanawha County arrived in plenty of time for the first session of the House of Delegates. Left to right: Drs. A. Thomas McCoy of Charleston, Donald E. Cunningham of St. Albans, Pat A. Tuckwiller of Charleston, and Joseph A. Smith of Dunbar.

(6) Drs. Frank J. Holroyd of Princeton (left) and Richard V. Lynch, Jr., of Clarksburg, the new President, sign in at the registration desk.

(7) Doctor and Mrs. Lynch exchange pleasantries with two guests at the reception honoring new officers Saturday evening.

(8) Doctor Lynch discusses Association business with Drs. Forest A. Cornwell (left) and Richard G. Starr, both of Beckley.

(9) Enjoying a coffee break between scientific sessions are (left to right): Drs. Louis W. Groves, Jr., of Richwood, J. L. Mangus of Charleston and R. L. Chamberlain of Buckhannon.

(10) Mrs. Wilson P. Smith of Huntington, Past President of the Auxiliary, presents AMA-ERF check to Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine.

(11) This picture of part of the Cabell County Delegation shows (left to right): Drs. Albert C. Esposito, I. Ewen Taylor and James S. Klumpp, all of Huntington. Doctors Esposito and Klumpp are Past Presidents of the Association.

(12) Dr. and Mrs. A. B. Curry Ellison of Charleston were among the first to arrive at Governor's Hall for the first general scientific session.

(13) Chatting during a break are Drs. W. Hampton St. Clair, Jr., (left) and John J. Mahood, both of Bluefield.

Action Taken on Amendments To Constitution and By-Laws

The House of Delegates of the West Virginia State Medical Association adopted several amendments to the Constitution and By-Laws during the 1967 Annual Meeting at The Greenbrier.

Final action was taken on three proposed amendments to the Constitution which were offered initially at the Annual Meeting in 1966. All three amendments were offered in order to bring the Constitution into conformity with the By-Laws.

The following three amendments to the Constitution were adopted:

Article IX, Section 1, Line 3—Delete the word, "twelve," and substitute therefor the word, "fifteen."

Section 2, Line 4—Delete the words, "each year," and substitute therefor the words, "every second year as shall be provided for in the By-Laws for reapportionment of Councilor Districts."

Section 2, Paragraph 3, Line 4—Add ", except as provided in the By-Laws pertinent to reapportionment of Councilor Districts."

Amendments to the By-Laws

Several major amendments to the By-Laws were adopted, one of which will make it possible for a physician holding a temporary permit to practice medicine to become a member of the State Medical Association providing he is a member in good standing in his component society.

The following four amendments to the By-Laws were adopted by the House of Delegates:

Amend Chapter 1, Section 6, By-Laws, by adding as paragraph two the following:

The grant of a temporary permit to practice medicine by the Medical Licensing Board of West Virginia shall entitle the holder of such temporary permit to full privileges of active membership in the State Medical Association during the period covering such temporary permit, provided such permit holder has satisfied the requirements for membership in his component society. There shall be no remission of dues or assessments for any portion of any fiscal year not covered by the terms of a temporary permit to practice medicine in this State, or when said temporary permit has been revoked by competent authority during said fiscal year. The fiscal year shall begin on January 1 and end on December 31 each year.

Amend Chapter VII, Section 10, By-Laws, by transferring Taylor County from District II to District VI.

Amend Chapter VII, Section 2, by inserting the following after the clause "and one Councilor from each odd-numbered district to serve a term of 2 years, ":

"except that District XI shall be entitled to two Councilors, to be elected in 1967, one for a one-year term and the second Councilor elected for a term of two years, and thereafter one shall be elected for a two-year term in each succeeding year."

Amend Chapter IV, Section 2, by deleting the first sentence and substituting therefor the following:

"Each component society shall be entitled to elect and send to the House of Delegates each year one delegate who shall be the society's secretary, and one additional delegate for every 20 members or fraction thereof."

Proposed Constitutional Amendments

One proposed amendment to the Constitution was offered at the first session of the House of Delegates. The amendment would make all past presidents lifetime members of the House of Delegates. The amendment will be submitted to the House of Delegates for final action at the 101st Annual Meeting at The Greenbrier, August 22-24, 1968.

Dr. Richard E. Flood of Weirton (at right in left photo), President of the Association, greets Mr. and Mrs. Mitchell Sagan of Weirton at a reception in his suite. Mr. Sagan designed the colorful Centennial seal, which has been the hallmark of the Association this year. In right photograph are shown two officials of AMPAC who were guests at the meeting. At left is Dr. Blair J. Henningsgaard of Astoria, Oregon, Chariman of the AMPAC Board of Directors; and Mr. Joseph Miller of Chicago, Executive Director.

The roving photographer
captured many
happy smiles at

THE CENTENNIAL BANQUET

The Greenbrier
August 25

Dr. Joseph A. Smith of Dunbar (left), Chairman of the Golf Committee, presents a trophy to Dr. George A. Curry of Morgantown. Doctor Curry posted the lowest score among physicians participating in the annual Medical Golf Tournament.

Dr. George A. Curry Wins Golf Tournament

Dr. George A. Curry of Morgantown posted the lowest score among physicians in the Medical Golf Tournament, which was conducted during the Centennial Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs in August.

Doctor Curry shot an 80 to win the tournament.

An exhibitor, Mr. V. R. Facciuto, posted a 75, lowest score of the tournament, and was awarded an appropriate prize.

Other leading low gross scores included: Dr. Vernon Hutton of Nashville, Tennessee, 81; Dr. C. E. McKay of Huntington, 81; Dr. W. C. Morgan of Charleston, 81; and Dr. C. D. Cottrell of Charleston, 82.

Dr. William E. Gilmore of Parkersburg had a low net of 71, to win first place in that category. Others among the best low net scores were: Dr. R. A. Crawford of Charleston, 73; Dr. R. C. Aliff of Tampa, Florida, 73; Dr. J. P. Aliff of Charleston, 74; Dr. L. Dale Simmons of Clarksburg, 74; and Dr. G. H. Pierson of Clendenin, 75.

Dr. C. F. McCord of Welch won the low putts prize with 29, and Dr. Upshur Higginbotham of Bluefield had the best blind bogey score of 71.

Dr. Joseph A. Smith of Dunbar was chairman of the tournament.

1968 Meeting at The Greenbrier

The Council, at its pre-convention meeting, voted to hold the 101st Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs. The meeting is scheduled for August 22-24, 1968.

More Attention Urged For Renal Disease

More attention to nephritis and nephrosis—kidney diseases accounting for over six per cent of the deaths in West Virginia in the past couple of years—was called for recently by State Health Director N. H. Dyer in the health department's weekly publication, "State of the State's Health."

The health official explained that nephritis and nephrosis are general terms for many kinds of kidney diseases of inflammatory nature. Some are due to bacteria; others, to blood vessel disease of the kidney and others of unknown causes. The killing and disabling results of these diseases are also variable. It may be acute and kill in a matter of weeks or chronic causing disability through a normal life span.

Of approximately 19,000 deaths in West Virginia in 1965 and 1966, 117 and 121 respectively were due to nephritis and nephrosis. Doctor Dyer reported that the figures to date in 1967 are paralleling 1965 and 1966.

"Much kidney disease can be prevented and treated but the problem of manpower and money, specifically trained and designated to accomplish this purpose, is the impediment to accomplishing this in West Virginia," Doctor Dyer said. "There are no physicians in the State devoting the majority of their time to the study and treatment of these kidney diseases. There is no research or patient services money allocated on either public or private basis for the purposes of investigating and treating the patient with chronic renal disease. And, there is no program for public or professional education devoted to the continuing process of informing the public as well as updating the profession in the care of the patient with chronic renal disease."

Kidney disease accounts for a large percentage of deaths due to chronic disease in the younger age groups from the ages 20 to 36; it amounts to 25 to 35 per cent of mortality due to chronic disease exceeding such conditions as neurological disease, diabetes mellitus, stroke, rheumatic heart disease and hypertensive disease, the health official pointed out.

Doctor Dyer said that statistics compiled by the National Health Survey and reported by the National Kidney Foundation reveal that the principal causes of work loss of American women are kidney related diseases of the genito-urinary system. These same diseases cause the second highest work loss in the United States today for population under age 35. The National Kidney Foundation (of which there is no representation in West Virginia) also states that from age 25 on, these kidney related diseases are the fourth highest cause of work loss. They further indicate that at least 3,300,000 Americans have unrecognized and undiagnosed kidney infection. The number in West Virginia would equal the population of Clarksburg, that is about 30,000.

In the area of pre-disease, Doctor Dyer suggested possible programs primarily directed toward health

protection systems include the following: developing community education programs to help increase public awareness of the renal disease problem: having yearly screening programs in offices, factories, schools, community centers, screening of newborns for congenital defects of the urinary tract; health education of females to encourage hygienic practices; recruitment and training of specialized personnel, and inclusion of an adequate urinary tract evaluation in the periodic health examinations.

In the area of acute phase programs, which are devoted primarily to early diagnosis and treatment, the following may be included: screening programs, public education programs stressing the need for early diagnosis and treatment, physician education programs with emphasis on the newer methods of diagnosis and treatment of kidney diseases, postgraduate educational programs on programmed self-instruction courses, improved facilities and staff for teaching the fundamentals of kidney diseases to medical and nursing students, prompt and thorough treatment of infections with appropriate antibodies, and adequate treatment of streptococcal infections anywhere in the body.

For programs devoted to the chronic phase problem, which are directed mainly at disability prevention and rehabilitation, the following may be done: vigorous treatment of cases of kidney disease discovered in the screening and examination programs, strict medical management of patients whose renal function is adequate to survive under such programs, artificial kidney centers for chronic dialysis, kidney transplantation programs, home dialysis for selected chronic patients, and job retraining for dialysis patients who must change occupation because of the in-dwelling cannulai.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Doctor Dyer noted that there are artificial kidneys scattered throughout the State. He said that their operators are doing a creditable job on a part-time basis but that personnel should be encouraged to continue to develop and should be used as a resource in the proper development of systems and programs such as the ones he had mentioned.

Doctor Dyer added that the health department is ready to play its usual role of consultation, coordination and assistance in the sound endeavors in this field.

Program Committee for 1968

Dr. Richard V. Lynch, Jr., President of the West Virginia State Medical Association, has appointed Dr. George F. Evans of Clarksburg as Chairman of the Program Committee for the 101st Annual Meeting of the Association, which will be held at The Greenbrier in White Sulphur Springs, August 22-24, 1968.

Serving on the Committee with Doctor Evans will be Drs. Charles E. Andrews of Morgantown, Joe N. Jarrett of Oak Hill, A. J. Villani of Welch and Kenneth G. MacDonald of Charleston.

Dr. William B. Walsh of Washington (left photo), his wife and youngest son, Tom, enjoyed a brief working vacation during the Annual Meeting at The Greenbrier. Doctor Walsh, Founder, Medical Director and President of Project HOPE, was an honor guest at the Centennial Meeting. In right photo, Dr. Mildred M. Bateman (left), State Mental Health Director, and Dr. Cornelia B. Wilbur, former Superintendent of Weston State Hospital, chat with Dr. Dana L. Farnsworth at the Department of Mental Health exhibit. Doctor Farnsworth, a native of Gilmer County and now Director of University Health Services at Harvard University, was a guest speaker at the Annual Meeting.

Pre-Convention Council Meeting At The Greenbrier, Aug. 23

The pre-convention meeting of the Council was held at The Greenbrier in White Sulphur Springs on Wednesday morning, August 23, 1967, with the Chairman, Dr. Seigle W. Parks of Charleston, presiding.

Doctor Parks introduced a guest at the meeting, Dr. Milford O. Rouse of Dallas, Texas, President of the American Medical Association, who presented brief remarks.

It was reported that only one resolution had been submitted for consideration by the House of Delegates. Also, Doctor Parks said policy statements on the subjects of alcoholism and chiropractic would be offered for approval by the House. (The resolution and policy statements adopted by the House of Delegates appear elsewhere in this issue of *The Journal*).

Dr. James S. Klumpp, Chairman of the Constitution and By-Laws Committee, reported that three amendments to the Constitution, offered during the 1966 Annual Meeting, would be acted upon at the first session on Wednesday afternoon.

Doctor Klumpp also reported that the Committee would offer several proposed amendments to the Constitution and By-Laws at the first session of the House. The Council approved the report and commended the Committee for its work during the past year. (The amendments adopted by the House of Delegates appear elsewhere in this issue of *The Journal*).

Report of Medical Economics Committee

Drs. George R. Callender, Jr., and Harry S. Weeks, Jr., presented lengthy and detailed reports on the activities of the Medical Economics Committee.

Doctor Callender reported there had been a series of negotiations with officials of the Workmen's Compensation Fund in an effort to have the fee schedule discarded and the system of usual and customary charges accepted as the basis of payment to physicians for services rendered to Compensation patients.

Doctor Weeks reported that members of the Joint Conference Committee had met in June with Commissioner Vincent of the Welfare Department and it was reported at that time that approximately 10 per cent of the vouchers received by the Department were being returned to physicians for one reason or another. Doctor Weeks said that the primary reason for the vouchers being returned was that they had been filled out improperly in the physicians' offices.

Doctor Weeks said that the Commissioner had made every effort possible to pay physicians their usual and customary charges. He said that the Department still did not have the necessary information to appear before the Legislature with a request for additional funds.

Report of Welfare Officials

Commissioner L. L. Vincent of the Department of Welfare was invited to attend the Council meeting and he was accompanied by Dr. J. L. Mangus, part-time Medical Director of the Department.

The Commissioner said he appreciated the wonderful cooperation of physicians throughout the State and also acknowledged the fine help he had received from Doctor Mangus since he joined the staff.

He discussed the many problems the Department has encountered in the implementation of the Medicare law, as well as Title XIX. He said the program could not succeed without the support of practicing physicians.

Commissioner Vincent stated again that the "State has no right to expect a discount from physicians or any other provider of services." He also reported that the family caseload in the Welfare program had been reduced from 63,000 in 1961 to 42,000 in 1967.

Merger of B-R-T and Taylor Societies

It was reported that the members of the B-R-T and the Taylor County Medical Societies had voted to merge and that the House of Delegates would be asked for its approval during the meeting (merger was approved and the new society was named the Tygart Valley Medical Society).

Election of Honorary Member

The Council elected Dr. James E. Fisher of New Cumberland to honorary life membership in the State Medical Association.

Doctor Wilbar Appears Before Council

Dr. Charles L. Wilbar, Jr., Director of the West Virginia Regional Medical Program for Heart Disease, Cancer and Stroke, appeared before the Council to discuss the program which is based at the West Virginia University Medical Center in Morgantown.

Doctor Wilbar, who served for 10 years as Secretary of Health in Pennsylvania, also has been appointed Clinical Professor of Medicine in Preventive Medicine and Public Health at the West Virginia University School of Medicine.

Auxiliary Advisory Board

It was reported that Mrs. Rupert W. Powell of Fairmont had submitted for approval by the Council, the following list of physicians to serve as members of the Medical Advisory Board to the Auxiliary during her term of office as President: Dr. Richard E. Flood of Weirton, Chairman; Drs. Hu C. Myers of Philippi; M. Bruce Martin of Huntington; George A. Curry of Morgantown; and Rupert W. Powell of Fairmont.

The Council approved the appointment of the above named physicians to serve as members of the Advisory Board.

Retiring Councilors

Doctor Parks reported that three physicians had completed four years of service as members of the Council and therefore would not be eligible for re-election: Drs. Maynard P. Pride of Morgantown; I. Ewen Taylor of Huntington; and Buford W. McNeer of Hinton.

The Council went on record unanimously as expressing gratitude to Dr. Seigle W. Parks for his able guidance as Chairman of the Council during the past year.

The Council meeting was attended by: Dr. Seigle W. Parks of Charleston, Chairman; Dr. Richard E. Flood of Weirton, President; Dr. Richard V. Lynch, Jr., of Clarksburg, President Elect; Dr. Richard W. Corbitt of Parkersburg, Vice President; Dr. Kenneth G. MacDonald of Charleston, Treasurer; Dr. Albert C. Esposito of Huntington, Councilor-at-large; Dr. L. J. Pace of Princeton, member of the Executive

Committee; and Drs. Maynard P. Pride of Morgantown; S. Elizabeth McFetridge of Shepherdstown; R. L. Chamberlain of Buckhannon; Andrew J. Weaver of Clarksburg; I. Ewen Taylor of Huntington; William E. Gilmore of Parkersburg; A. J. Villani of Welch; W. P. Bittinger of Oak Hill; George R. Callender, Jr., of Charleston; and Mr. William H. Lively, Secretary ex officio.

The meeting also was attended by Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. James S. Klumpp of Huntington, Parliamentarian; Dr. N. H. Dyer of Charleston, Director of the State Department of Health; Dr. Harry S. Weeks, Jr., Co-Chairman of the Medical Economics Committee; Dr. Milford O. Rouse of Dallas, Texas, President of the American Medical Association; Dr. Charles L. Wilbar of Morgantown, Director of the West Virginia Regional Medical Program for Heart Disease, Cancer and Stroke; Mr. David B. Weihaupt, AMA Field Representative; Commissioner L. L. Vincent, State Department of Welfare; and Dr. J. L. Mangus of Charleston.

ACS Plans Fall Meeting At Medical Center

The West Virginia Chapter, American College of Surgeons, will conduct its fall scientific session on Friday and Saturday, November 17-18, at the West Virginia University Medical Center in Morgantown.

The title of the program is "Surgical Aspects of Trauma."

Speakers will include: Dr. John F. Perry, Jr., Ancker Hospital, St. Paul, Minnesota; Dr. Frederick W. Ackroyd, Surgical Service, City Hospital, Boston, Massachusetts; and Dr. Walter A. Hoyt, Jr., Children's and City Hospitals, Akron, Ohio.

The program will begin at 9 A.M. in the main auditorium of the Medical Center on Friday and will continue through Saturday morning. Tickets to the West Virginia University-Davidson football game have been set aside for physicians wishing to attend on Saturday afternoon.

All members of the medical profession are invited to attend the meeting.

Additional information may be obtained by writing to Dr. Richard A. Currie, Department of Surgery, WVU Medical Center, Morgantown.

Centennial Meeting Attended By 5 State Presidents

The presidents of the medical associations of five states in addition to West Virginia attended the 100th Annual Meeting of the State Medical Association at The Greenbrier.

They are: Dr. Robert E. Pennington, Kentucky; Dr. Newton DuPuy, Illinois; Dr. R. D. Bauer, Maryland; Dr. R. E. Howard, Ohio; and Dr. J. E. McClenahan, Pennsylvania.

Dr. George W. Petznick, a Past President of the Ohio State Medical Association, also attended.

Association's First PG Course Termed Successful

The first postgraduate medical education course sponsored by the West Virginia State Medical Association was generally regarded as successful.

More than 40 physicians from many parts of the State attended the course in "Cardiac Auscultation Review With Case Presentations," which was conducted on Saturday, September 9, at Herbert J. Thomas Memorial Hospital in South Charleston.

The five-hour course was sponsored by the Association's Committee on Medical Education and Hospitals in cooperation with Cabell-Huntington Hospital, the Cabell-Wayne Heart Association, and the West Virginia Department of Health. Four hours of postgraduate credit was allowed by the American Academy of General Practice for attendance by its members.

Faculty was composed of Dr. D. Sheffer Clark of Huntington and Dr. Robert J. Marshall of Morgantown, Professor of Medicine at West Virginia University School of Medicine. They were assisted by four cardiologists and internists from the Charleston area.

Arrangements for the course were made by Dr. Edwin M. Shepherd of Charleston, the Committee's Educational Coordinator for the Charleston Area. Although the course was intended primarily for physicians in counties surrounding Charleston, it drew physicians from such scattered communities as Morgantown, Bluefield, Summersville, and Clarksburg.

A highlight of the course was the presentation of four "live" cases by their physicians. Four girls and women, ranging in age from 10 to 42, and representing various types of heart defects, were present to have their cases described by their physicians.

The cases were presented by Drs. James H. Getzen, Harold Selinger, John M. Hartman and William A. Thornhill, Jr., all of Charleston.

Through the use of electronic equipment and approximately 35 stethophones, the physicians were able to listen to the patients' hearts simultaneously as each attending physician described the case under study.

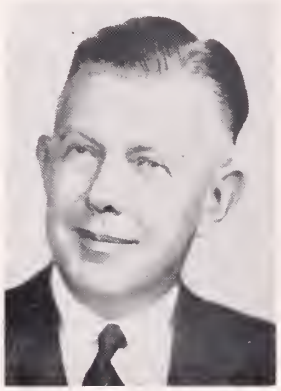
A course evaluation questionnaire was filled out by physicians attending the program, and a preliminary examination of the results indicated the course was highly effective. Results will be reported in a future issue of *The Journal.*

Dr. Pat A. Tuckwiller of Charleston, Chairman of the Committee, said the course was arranged around the Committee's philosophy that postgraduate education should be presented in a hospital setting, using live patient demonstrations and drawing on the teaching talents of West Virginia physicians.

Additional one-day courses for other areas of the State are in the planning stage. The Committee has scheduled a planning session for Oglebay Park in Wheeling on October 1.

12th Annual Postgraduate Institute In Martinsburg, Oct. 27-29

Dr. Virginia Apgar of Tenafly, New Jersey, a noted specialist in the problems of newborns, will be one of the featured speakers at the 12th Annual Potomac-Shenandoah Valley Postgraduate Institute, which will be held in Martinsburg, October 27-29.



John C. Krantz, Jr., Ph. D.

Virginia Apgar, M. D.

More than a score of papers will be presented during the three-day program by authorities in the basic sciences, pediatrics, obstetrics and gynecology, surgery, medicine and other fields. In addition to the lectures, there will be roundtable luncheons and social events.

Scientific sessions will be conducted in the Apollo Theater, and exhibits will be housed in the Shenandoah Hotel. The program is sponsored jointly by the West Virginia Chapter, American Academy of General Practice, and the Potomac-Shenandoah Valley Postgraduate Institute.

Members of the Academy of General Practice may receive up to 19 hours of credit by attending the Institute. There will be no Sunday afternoon program this year.

Friday Morning Session

The first session on Friday morning, October 27, will be devoted to papers on basic science and pediatrics. Speakers and their subjects will be:

"Some of the Newer Analgesics"—Raymond M. Burgison, M. D., Head of the Department of Pharmacology, University of Maryland School of Dentistry, Baltimore.

"Hip Disorders in Children"—Joseph M. LoPresti, M. D., Associate Clinical Professor of Pediatrics, Georgetown and George Washington University Schools of Medicine, Washington, D. C.

"Early Diagnosis of Hidden Congenital Anomalies" —Virginia Apgar, M. D., Tenafly, New Jersey.

"Treatment of Diabetes Mellitus in Childhood"—Hans G. E. Keitel, M. D., former Professor and Head of the Department of Pediatrics, Jefferson Medical College, Philadelphia.

"Interesting and Unusual Conditions in the Neonatal Period"—McLemore Birdsong, M. D., Professor of Pediatrics, University of Virginia School of Medicine, Charlottesville.

Doctor Keitel will moderate a panel discussion at the end of the morning session. A roundtable luncheon will follow, with a visiting speaker presiding at each table.

Friday Afternoon Program

The afternoon session on Friday will be devoted to surgical topics. Speakers and their topics will be:

"Fluid and Electrolyte Balance in Simple Intestinal Obstruction"—Robert W. Buxton, M. D., Professor and Head of the Department of Surgery, University of Maryland School of Medicine, Baltimore.

"Orthopedic Procedures for the Arthritic Patient"—Justus C. Pickett, M. D., Professor and Head of the Division of Orthopedic Surgery, West Virginia University School of Medicine, Morgantown.

"Rectal Lesions"—George H. Yeager, M. D., Professor of Surgery, University of Maryland School of Medicine, Baltimore.

"Indications for Urologic Surgery in Children"—John D. Young, M. D., Professor and Head of the Department of Urology, University of Maryland School of Medicine, Baltimore.

Friday Night Dinner

Dr. John C. Krantz, Jr., internationally known pharmacologist, will be the after-dinner speaker on Friday evening. Doctor Krantz, Professor Emeritus of Pharmacology at the University of Maryland School of Medicine, will speak on "On Having An Educated Heart."

Saturday Morning Program

Speakers in the basic sciences and in obstetrics and gynecology will present the program on Saturday morning. Speakers and their subjects are as follows:

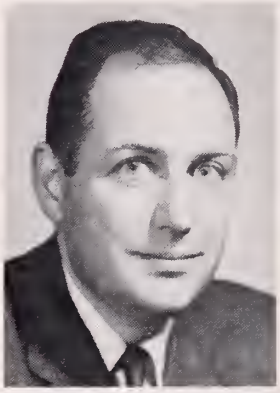
"The Psychology and Pharmacology of Angiotensin"—William W. Fleming, Ph. D., Chairman of the Department of Pharmacology, West Virginia University School of Medicine, Morgantown.

"Anatomical Basis for the Examination of the External Female Genitalia"—Robert J. Johnson, M. D., Professor and Head of the Department of Anatomy, University of Pennsylvania Graduate School of Medicine, Philadelphia.

"Apgar on Apgar"—(This very important film has been shown all over the world).

"Abnormal Glucose Tolerance Test in Pregnancy" —Harold R. Misenhimer, M. D., Assistant Professor of Obstetrics and Gynecology, University of Maryland School of Medicine, Baltimore.

"Endometrial Carcinoma"—Leo J. Dunn, M. D., Professor and Head of the Department of Ob-



Theodore G. Duncan, M. D.

Mrs. Esther Tufty

stetrics and Gynecology, Medical College of Virginia, Richmond.

"The Use of Oxytocics in Obstetrics"—James G. Sites, M. D., Associate Professor of Obstetrics and Gynecology, George Washington University School of Medicine, Washington.

Dr. Philip Steptoe, Associate Professor of Obstetrics and Gynecology at Georgetown University School of Medicine, Washington, will serve as a moderator of a panel discussion which will conclude the morning session. This will be followed by another round-table luncheon.

Saturday Afternoon Session

Papers on medical topics will be given at the session on Saturday afternoon. The speakers and their subjects will be as follows:

"The Evaluation and Management of the Diabetic Patient Requiring Surgery"—Theodore G. Duncan, M. D., University of Pennsylvania School of Medicine, Philadelphia.

"Intensive Care Unit Management of the Coronary"—Alphonse C. Edmundowicz, Harrisburg, Pennsylvania, former Assistant Professor of Medicine, West Virginia University School of Medicine, Morgantown.

"Drug Interaction"—John C. Krantz, Jr., Ph. D., Emeritus Professor of Pharmacology, University of Maryland School of Medicine, Baltimore.

"Allergy to Stinging Insects"—Halla Brown, M. D., Professor of Medicine and Chief of Allergy, George Washington University School of Medicine, Washington.

Saturday Night Banquet

Mrs. Esther Von Wagoner Tufty, a well known correspondent, will be the principal speaker at the Annual Banquet Saturday night. Mrs. Tufty, who operates her own news agency and who has been to Viet Nam recently, will speak on "Washington Sidelights and Insights." A question and answer period will follow.

Sunday Morning Program

The program on Sunday morning will be devoted to medicine and basic science. The program is as follows:

"Anatomical Basis for the Examination of the Oral Cavity"—Robert J. Johnson, M. D., Professor and Head of the Department of Anatomy, University of Pennsylvania Graduate School of Medicine, Philadelphia.

"Gastrointestinal Tract in Diabetes"—Walter L. Henry, M. D., Head of the Department of Medicine, Howard University of School of Medicine, Washington.

"Hyperthyroidism—Today's Tests" — Thomas H. McGavack, M. D., Chief of Research, Veterans Administration Center, Martinsburg.

"Dermatology in the Geriatric Patient"—Raymond C. V. Robinson, M. D., Associate Professor of Dermatology, University of Maryland School of Medicine, Baltimore.

"The Clinical History in the Management of Seizures"—Charles Van Buskirk, M. D., Clinical Professor of Neurology, University of Maryland School of Medicine, Baltimore.

"Methods of Sero-diagnosis in Syphilis"—Charles McKenna, M. D., Outpatient Clinic, Johns Hopkins Medical School, Baltimore.

"The Management of Complete Heart Block"—Robert J. Marshall, M. D., Professor of Medicine, West Virginia University School of Medicine, Morgantown.

Sunday Luncheon

The Sunday luncheon speaker will be Mr. James C. Bostain, Scientific Linguist of the Foreign Service Institute, U. S. State Department. His subject will be "Read Your Patient."

Registration Fee

The registration fee is $25 for the entire three-day course, and $10 for a single day. Additional information may be obtained by writing to Dr. Halvard Wanger, Executive Director, Box 175, Shepherdstown, West Virginia.

Catholic Bishop Joseph B. Brunini of Jackson, Mississippi, (center in left picture), converses with two Past Presidents of the Association from Huntington. At left is Dr. Albert C. Esposito. At right is Dr. Ray M. Bobbitt. Dr. J. Howard Anderson of Hemphill (center in right photo), who served as President of the Association in 1921, attended the Past Presidents' Luncheon at The Greenbrier. With Doctor Anderson are Dr. Russel Kessel (left) and Dr. Thomas G. Reed, both of Charleston.

Mrs. Rupert W. Powell Installed As Auxiliary President

Mrs. Rupert W. Powell of Fairmont was installed as President of the Woman's Auxiliary to the West Virginia State Medical Association during the Auxiliary's 43rd Annual Meeting at The Greenbrier in White Sulphur Springs, August 24-26, 1967.

Mrs. Rupert W. Powell

Mrs. Powell, whose husband is a radiologist in Fairmont, succeeds Mrs. Hu C. Myers of Philippi.

More than 230 physicians' wives attended the Auxiliary sessions, which were held in conjunction with the Centennial Meeting of the State Medical Association.

Mrs. Karl F. Ritter of Lima, Ohio, President of the Woman's Auxiliary to the American Medical Association, presided at the installation of Mrs. Powell and other officers on Friday morning, August 25.

Mrs. Ritter also gave the keynote address on Thursday, August 24. Other visitors to address or be presented to the Auxiliary during the meeting were: Dr. Richard E. Flood of Weirton, President of the West Virginia State Medical Association; Mrs. C. T. Wilkinson, President of the Woman's Auxiliary to the Southern Medical Association; Mrs. Chester Young, National AMA-ERF Chairman; Mrs. Frank Gastineau, a member of the Board of Directors of AMPAC; and Mrs. William B. Walsh, whose husband, Doctor Walsh, was a guest speaker at the State Medical Association meeting.

Other New Officers

Mrs. J. A. B. Holt of Charleston was named President Elect and will be installed at the Auxiliary's 44th Annual Meeting at The Greenbrier next August.

Other new officers for the coming year are as follows:

Mrs. Ray S. Greco of Weirton, First Vice President; Mrs. Warren D. Elliott of Beckley, Second Vice President; Mrs. Robert G. Janes of Fairmont, Third Vice President; Mrs. M. Bruce Martin of Huntington, Fourth Vice President; Mrs. J. Dennis Kugel of Charleston, Treasurer; Mrs. Richard G. Starr of Beckley, Recording Secretary; Mrs. George A. Curry of Mogantown, Corresponding Secretary; and Mrs. Pat A. Tuckwiller of Charleston, Parliamentarian.

Committee Chairmen

The following chairmen of standing committees were announced for the coming year:

Mrs. M. Bruce Martin of Huntington, AMA-ERF; Mrs. Joe N. Jarrett of Oak Hill, Archives and History; Mrs. William A. Thornhill, Jr., of Charleston, By-laws and Handbook; Mrs. James H. Walker of Charleston, Community Service; and Mrs. G. Thomas Evens of Fairmont, Convention.

Mrs. William T. Lawson of Fairmont, Convention Co-Chairman; Mrs. L. Dale Simmons of Clarksburg, Disaster Preparedness and Safety; Mrs. Richard K. Hanifan of Clarksburg, Editor, State News Bulletin; Mrs. Charles S. Harrison of Clarksburg, Circulation Manager, News Bulletin; and Mrs. Harry E. Beard of Huntington, Finance.

Mrs. William P. Sinclair of Wheeling, Health Careers; Mrs. Charles W. Merritt of Beckley, Legislation; Mrs. Clark K. Sleeth of Morgantown, Liaison to the Woman's Auxiliary to the Student American Medical Association; Mrs. J. A. B. Holt of Charleston, Membership: and Mrs. Paul P. Warden of Grafton, Members-at-Large.

Mrs. Harry C. Fleming of Fairmont, Mental Health; Mrs. Robert J. Tchou of Williamson, International Health Activities; Mrs. John D. Lindsay of Fairmont, National Bulletin and *MD's Wife;* and Mrs. Myer Bogarad of Weirton, Necrology.

Mrs. B. F. Puckett of Oak Hill, Press and Publicity; Mrs. Arthur A. Abplanalp of Charleston, Program; Mrs. Lynwood D. Zinn of Clarksburg, Rural Health and Nutrition; and Mrs. Charles L. Goodhand of Parkersburg, Southern Medical Councilor.

Mrs. Hu C. Myers of Philippi and Mrs. Wilson P. Smith of Huntington are Past Presidents who will serve on the Board of Directors for the coming year.

Medical Advisory Board

Five physicians were appointed to the Medical Advisory Board. They are: Dr. Richard E. Flood of Weirton; Dr. Hu C. Myers of Philippi; Dr. M. Bruce Martin of Huntington; Dr. George A. Curry of Morgantown; and Dr. Rupert W. Powell of Fairmont.

Inaugural Address

In her inaugural address, Mrs. Powell pointed out that auxiliaries are not independent organizations "but rather a part of the American Medical Association, its constituents or state associations and the components or county societies."

She said basic policies are determined by those organizations but "their interests and goals are ours too. These interests and goals are incentive for us to develop our activities and services for the benefit of our communities."

The President said the Auxiliary is "ready to furnish authentic health information to the public by again having reviewed our role as interpreters of our husbands' professional ideals.

"By so doing, we are taking the initiative; we, too, are applying local solutions to local problems; we are proving that we are not adopting the attitude that the government can do it; we are protecting the 'American way of life.' "

She called for a 10 per cent increase in the membership of the State Auxiliary and pledged the group to at least duplicate, if not surpass, last year's contributions to AMA-ERF, for which the Auxiliary won national honors.

Mrs. M. Bruce Martin of Huntington, AMA-ERF Chairman for the Woman's Auxiliary to the State Medical Association, displays a plaque awarded to the state unit at the AMA Auxiliary meeting in June for having the largest total contributions to AMA-ERF in its membership category. Looking on are Mrs. Wilson P. Smith (left) of Huntington, President of the State Auxiliary in 1965-66, and Mrs. Hu C. Myers of Philippi, who ended her term as President in August.

The New President

Active in Auxiliary affairs for many years, Mrs. Powell has held several offices at the state level, including those of President Elect, Vice President, Recording Secretary, and Chairman of Press and Publicity, News Bulletin Circulation and Today's Health. She is a Past President of the Woman's Auxiliary to the Marion County Medical Society.

Mrs. Powell holds a B. S. degree in home economics from West Virginia University, and taught in the secondary schools of West Virginia and Virginia. She is a member of the First Methodist Church of Fairmont and served on the official board for a number of years.

She has also been active in civic organizations and has seen service on the boards of the Woman's Division of the Greater Fairmont Development Association and the Marion County Chapter of the American Cancer Society.

New officers of the Woman's Auxiliary to the West Virginia State Medical Association, elected during the Annual Meeting at The Greenbrier in August, are shown in left photo. They are (left to right): Mrs. Rupert W. Powell of Fairmont, President; Mrs. J. A. B. Holt of Charleston, President Elect; Mrs. Ray S. Greco of Weirton, First Vice President; Mrs. Warren D. Elliott of Beckley, Second Vice President; Mrs. M. Bruce Martin of Huntington, Fourth Vice President; Mrs. Richard G. Starr of Beckley, Secretary; and Mrs. J. Dennis Kugel of Charleston, Treasurer. Absent when picture was made was Mrs. Robert G. Janes of Fairmont, Third Vice President. In right photo, four members of the Woman's Auxiliary to the Kanawha Medical Society inspect some old medical instruments and documents which were displayed during the meeting. They are (left to right): Mrs. Milton J. Lilly, Jr., Mrs. Page Seekford, Mrs. W. Alva Deardorff, and Mrs. Pat A. Tuckwiller, all of Charleston.

Standing and Special Committees Named by Doctor Lynch

Dr. Richard V. Lynch, Jr., of Clarksburg, President of the West Virginia State Medical Association, has appointed the majority of the standing and special committees which will function during his one-year term of office.

The list of committees, with but one exception, is as follows:

Aging

W. P. Bittinger, Oak Hill, Chairman; Thomas H. Blake, St. Albans; Myer Bogarad, Weirton; E. Lyle Gage, Bluefield; and Thomas H. McGavack, Martinsburg.

Cancer

Chauncey B. Wright, Huntington, Chairman; John J. Battaglino, Jr., Wheeling; F. Lloyd Blair, Parkersburg; W. Carroll Boggs, Wheeling; I. E. Buff, Charleston; L. Walter Fix, Martinsburg; William E. Gilmore, Parkersburg; Walter H. Gerwig, Clarksburg; David B. Gray, Charleston; Ray A. Harron, Bridgeport; Hu C. Myers, Philippi; W. Hampton St. Clair, Jr., Bluefield; John J. Schaefer, Charleston; H. Jackson Teets, Weirton; and Alvin L. Watne, Morgantown.

Constitution and By-Laws

James S. Klumpp, Huntington, Chairman; D. E. Greeneltch, Wheeling; Sobisca S. Hall, Clarksburg; J. C. Huffman, Buckhannon; Jack Leckie, Huntington; and L. J. Pace, Princeton.

Insurance

C. A. Hoffman, Huntington, Chairman; R. L. Chamberlain, Buckhannon; R. U. Drinkard, Wheeling; Upshur Higginbotham, Bluefield; Athey R. Lutz, Parkersburg; Kenneth G. MacDonald, Charleston; Buford W. McNeer, Hinton; and L. H. Mills, Clarksburg.

Interprofessional Relations

J. C. Huffman, Buckhannon, Chairman.

Sub-Committees

Medico-Legal: Paul H. Revercomb, Charleston, Chairman; W. L. Neal, Huntington; and Maynard P. Pride, Morgantown.

Medicine and Religion: Tracy N. Spencer, Jr., South Charleston, Chairman; V. L. Dyer, Petersburg; and E. Leon Linger, Clarksburg.

Medicine and Pharmacy: L. Dale Simmons, Clarksburg, Chairman; Andrew E. Amick, Lewisburg; and R. C. Cowan, Jr., Parkersburg.

Medical-Dental Liaison: George L. Armbrecht, Wheeling, Chairman; Alberto G. Capinpin, Charleston; and James A. Thompson, Clarksburg.

Nurses Liaison: Wilda S. Joseph, Wheeling, Chairman; Edward Jackson, St. Albans; and Benjamin M. Stout, Jr., Morgantown.

Legislative

Frank J. Holroyd, Princeton, Chairman; John T. Chambers, Charleston; E. M. Clubb, Jr., Weirton; George A. Curry, Morgantown; A. C. Esposito, Huntington; Paul E. Gordon, Clarksburg; D. E. Greeneltch, Wheeling; N. B. Groves, Martinsburg; John W. Hash, Charleston; Logan W. Hovis, Parkersburg; J. C. Huffman, Buckhannon; Frank V. Langfitt, Clarksburg; Jack Leckie, Huntington; Charles L. Leonard, Elkins; Charles W. Merritt, Beckley; David W. Mullins, Logan; Thomas G. Reed, Charleston; Carl C. Romine, Morgantown; Joseph D. Romino, Fairmont; William B. Rossman and Page H. Seekford, Charleston; Richard J. Stevens and I. Ewen Taylor, Huntington; David B. Thornburgh, Parkersburg; A. J. Villani, Welch; James H. Walker, Charleston; Stephen D. Ward, Wheeling; Henry F. Warden, Jr., Bluefield; and Ward Wylie, Mullens.

Maternal and Perinatal Fetal Welfare

Frederick H. Dobbs, Charleston, Chairman; Clarence H. Boso and Thomas J. Conaty, Huntington; Paul H. Cope, Wheeling; Robert D. Crooks, Parkersburg; Thomas G. Folsom, Huntington; N. W. Fugo, Morgantown; George L. Grubb, Charleston; C. S. Harrison, Clarksburg; Edwin J. Humphrey, III, Huntington; W. Gene Klingberg, Morgantown; A. Robert Marks, Clarksburg; Rose H. McClanahan, Charleston; Charles W. Merritt, Beckley; Meryleen B. Smith, Peterstown; A. J. Villani, Welch; and Gates J. Wayburn, Huntington.

Medical Aspects of Sports

Richard W. Corbitt, Parkersburg, Chairman; K. D. Bowers, Jr., Morgantown; C. B. Buffington, Wheeling; J. Marshall Carter, Huntington; R. L. Chamberlain, Buckhannon; George F. Fordham, Mullens; Henry R. Glass, Jr., Charleston; Joe N. Jarrett, Oak Hill; Jack C. Morgan, Fairmont, George Naymick, Weirton; W. H. Rardin, Beckley; George W. Rose, Clarksburg; and H. R. W. Vial, South Charleston.

Medical Economics

Harry S. Weeks, Jr., Wheeling, Chairman.

Sub-Committees

Federal Medical Activities: Charles M. Scott, Bluefield, Chairman; Forest A. Cornwell, Beckley; Richard K. Hanifan, Clarksburg; E. F. Heiskell, Jr., Morgantown; and James T. Spencer, Charleston.

State Workmen's Compensation: Theodore P. Mantz, Charleston, Chairman; Thomas J. Holbrook, Huntington; R. T. Humphries, Clarksburg; George Naymick, Weirton; J. C. Pickett, Morgantown; Robert J. Sidow, Fairmont; and Clifford A. Stevenson, Beckley.

Blue Cross-Blue Shield Third Party: Charles E. Andrews, Morgantown, Chairman; Carter F. Cort, Fairmont; C. A. Hoffman, Huntington; Ray M. Kessel, Logan; Milton J. Lilly, Jr., Charleston; Athey R. Lutz, Parkersburg; and Lynwood D. Zinn, Clarksburg.

Public Welfare—Joint Conference Committee: Harry S. Weeks, Jr., Wheeling, Chairman; Richard E. Flood, Weirton; N. B. Groves, Martinsburg; Carl B. Hall, Charleston; W. Gene Klingberg, Morgantown; Thomas P. Long, Man; A. Thomas McCoy, Charleston; W. Fred Richmond, Beckley; Charles W. Thacker, Parkersburg; and J. D. H. Wilson, Clarksburg.

Medical Education and Hospitals

Pat A. Tuckwiller, Charleston, Chairman; Rowland H. Burns and D. Sheffer Clark, Huntington; Harry F.

Coffman, Keyser; Forest A. Cornwell, Beckley; Dwight P. Cruikshank, Parkersburg; Del Roy R. Davis, Kingwood; John H. Gile and William E. Gilmore, Parkersburg; Daniel Hamaty, Charleston; F. A. Hamilton, Jr., Martinsburg; Upshur Higginbotham, Bluefield; George M. Kellas, Wheeling; Jack Leckie, Huntington; John D. Lindsay, Fairmont; John J. Mahood, Bluefield; David Z. Morgan, Morgantown; Thomas G. Reed, Charleston; Howard B. Sauder, Wheeling; Edwin M. Shepherd, Charleston; Richard G. Starr, Beckley; William A. Thornhill, Jr., Charleston; William N. Walker, Jr., Bridgeport; and Halvard Wanger, Shepherdstown.

Medical Emergencies and Civil Defense

John J. Mahood, Bluefield, Chairman; Harold D. Almond, Buckhannon; Dominic A. Brancazio, Weirton; Harry F. Coffman, Keyser; Salvador Diaz, Huntington; Ernest G. Guy, Philippi; Charles H. Hiles, Wheeling; John A. B. Holt, Charleston; Joseph T. Mallamo, Fairmont; Edwin C. Neville, Charleston; Homer D. Martin, Dailey; James G. Ralston, Clarksburg; William S. Sadler, Barboursville; John W. Whitlock, Beckley; and E. Andrew Zepp, Martinsburg.

Mental Health

Boylston D. Smith, Jr., Clarksburg, Chairman; Mildred Mitchell-Bateman, Charleston; Randall Connolly, Vienna; Roy A. Edwards, Jr., Huntington; Ray S. Greco, Weirton; Thomas S. Knapp, Charleston; S. Elizabeth McFetridge, Shepherdstown; L. J. Pace, Princeton; William B. Rossman, Charleston; A. L. Wanner and Stephen D. Ward, Wheeling; Charles C. Weise, Charleston; William E. Wilkinson, Beckley; and A. C. Woofter, Parkersburg.

Military Medical Affairs

Russel Kessel, Charleston, Chairman; Bert Bradford, Charleston; Robert D. Hess, Bridgeport; Charles M. Scott, Bluefield; and Ward Wylie, Mullens.

Program

George F. Evans, Clarksburg, Chairman; Charles E. Andrews, Morgantown; Joe N. Jarrett, Oak Hill; Kenneth G. MacDonald, Charleston; and A. J. Villani, Welch.

Public Service

Albert C. Esposito, Huntington, Chairman; John M. Bobbitt, Huntington; George A. Curry, Morgantown; C. R. Davisson, Weston; Leonard M. Eckmann, South Charleston; G. Thomas Evans, Fairmont; S. William Goff, Parkersburg; N. B. Groves, Martinsburg; Carl E. Johnson, Morgantown; E. Lee Jones, Wheeling; Charles W. Merritt, Beckley; L. J. Pace, Princeton; W. Hampton St. Clair, Jr., Bluefield; Page H. Seekford, Charleston; Jack J. Stark, Belpre, Ohio; A. C. Thompson, Elkins; Stephen D. Ward, Wheeling; and A. J. Weaver, Clarksburg.

Resolutions

Seigle W. Parks, Charleston, Chairman; Albert C. Esposito, Huntington; J. C. Huffman, Buckhannon; Nime K. Joseph, Wheeling; and Charles L. Leonard, Elkins.

Rehabilitation

Buford W. McNeer, Hinton, Chairman; C. B. Buffington, Wheeling; Jean P. Cavender, Charleston; James A. Heckman, Huntington; Ralph H. Nestmann, Charleston; J. C. Pickett, Morgantown; L. Dale Simmons, Clarksburg; Harold B. Sunday, Charleston; Robert R. Weiler, Wheeling; and Leonard E. Yurko, Weirton.

Rural Health

Martha Jane Coyner, Harrisville, Chairman; Harold D. Almond, Buckhannon; Andrew E. Amick, Lewisburg; J. C. Arnett, Rowlesburg; B. S. Brake, Clarksburg; Del Roy R. Davis, Kingwood; N. H. Dyer, Charleston; Vernon L. Dyer, Petersburg; Earl L. Fisher, Gassaway; Robert R. Frye, Mannington; O. M. Harper, Clendenin; Mehmet V. Kalaycioglu, Shinnston; Charles T. Lively, Weston; Ralph McGraw, Follansbee; and Charles E. Staats, Charleston.

Syphilis

N. H. Dyer, Charleston, Chairman; Paul L. McCuskey, Parkersburg; C. Y. Moser, Kingwood; Frank M. Peck, Huntington; David S. Pugh, Chester; Thomas L. Thomas, Wheeling; Lyle D. Vincent, Parkersburg; and James E. Wise, Follansbee.

Tuberculosis

Hugh S. Edwards, Beckley, Chairman; Charles E. Andrews, Morgantown; J. M. Brand, Chester; Oliver H. Brundage, Parkersburg; William L. Cooke, Charleston; N. Allen Dyer, Bluefield; George F. Evans, Clarksburg; Ralph H. Nestmann, Charleston; Robert J. Reed, III, Wheeling; M. A. Viggiano, New Martinsville; James H. Walker, Charleston; M. L. White, Jr., Huntington; and David H. Williams, Weirton.

SPECIAL COMMITTEES

AMA-ERF

J. Keith Pickens, Clarksburg, Chairman; Irwin M. Bogarad, Weirton; Harry F. Cooper, Beckley; John E. Echols, Richwood; Robert J. Fleming, Morgantown; John H. Gile, Parkersburg; Joseph Gilman, Clarksburg; Daniel Hale, Princeton; Joe N. Jarrett, Oak Hill; Buford W. McNeer, Hinton; David Z. Morgan, Morgantown; Jack C. Morgan, Fairmont; Earl S. Phillips, Wheeling; Donald R. Roberts, Elkins; George A. Shawkey, Charleston; Wilson P. Smith, Huntington; John W. Trenton, Kingwood; Lysle T. Veach, Petersburg; and E. Andrew Zepp, Martinsburg.

School Health

Peter A. Haley, Charleston, Chairman; J. M. Brand, Chester; Hugh M. Brown, Clarksburg; Grover C. Hedrick, Jr., Beckley; Robert G. Janes, Fairmont; Thomas G. Folsom, Huntington; A. M. Jones, Parkersburg; Paul C. Soulsby, St. Albans; Thomas L. Thomas, Wheeling; and Eli J. Weller, Weirton.

WVU Liaison

Thomas L. Harris, Parkersburg, Chairman; Randall Connolly, Vienna; Albert C. Esposito, Huntington; John M. Hartman, Charleston; J. C. Huffman, Buckhannon; George M. Kellas, Wheeling; Claude S. Lawson, Jr., Fairmont; J. P. McMullen, Wellsburg; L. J. Pace, Princeton; W. Hampton St. Clair, Jr., Bluefield; John E. Stone, Huntington; Lawrence B. Thrush, Clarksburg; C. Carl Tully, South Charleston; and Frank J. Zsoldos, Mullens.

House of Delegates Adopts Two Policy Statements

The House of Delegates of the West Virginia State Medical Association unanimously adopted the following two statements of policy during the 100th Annual Meeting, August 24-26, 1967:

STATEMENT OF POLICY ON CHIROPRACTIC

It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease. Chiropractic constitutes a hazard to rational health care in the United States because of the substandard and unscientific education of its practitioners and their rigid adherence to an irrational, unscientific approach to disease causation.

In 1965, a United States District Court, in upholding a state's constitutional right to refuse to license chiropractors, said that "since chiropractic claims to be a complete and independent healing art capable of curing almost all kinds of disease, the state Legislature may have felt that the requirement of a foundation in materia medica and surgery . . . would be a protection to the public." Without dissent, the United States Supreme Court affirmed the decision.

The wisdom of these decisions by the nation's highest courts justifies the medical profession's educational program of alerting the nation to the public health threat posed by the cult of chiropractic.

Patients should entrust their health care only to those who have a broad scientific knowledge of diseases and ailments of all kinds, and who are capable of diagnosing and treating them with all the resources of modern medicine. The delay of proper medical care caused by chiropractors and their opposition to the many scientific advances in modern medicine, such as life-saving vaccines, often ends with tragic results.

STATEMENT OF POLICY ON ALCOHOLISM

Alcoholism symptomatology occurs in many personality disorders and comes within the scope of medical practice.

Acute alcoholism is a medical emergency. As with any other acute medical condition, the merits of each individual case should be considered at the time of the emergency.

The alcoholic patient admitted to a general hospital should be judged on his individual needs, with primary consideration being given the attending physician's opinion. The general hospital is the logical place for this patient to receive treatment. The exclusion from admission of any sick patient, including alcoholics, acute and chronic, has no place in the by-laws of a general hospital.

Physicians are the first line of defense against alcoholism. Many recognizable symptoms of excessive and compulsive drinking are present for several years before hospitalization is required. The physician should initiate treatment before the chronic or addictive stage of the illness appears. The most pronounced symptom of this progressive chronic illness is social disorder, manifested at first within the family and later in the area of employment. Alcoholism cannot appear in isolation, progress in isolation, or maintain itself in isolation. It takes two or more persons to make an alcoholic and the other person or persons must be educated and, if need be, enter into therapy before recovery from alcoholism may be anticipated on a lasting basis.

Understanding the functioning personality of the alcoholic patient involves the reaction role of the family. The degree of success of recovery depends largely upon meeting the needs of the family in breaking the destructive symbiosis which this illness produces between the patient and the family. The physician who has as a patient the spouse, parent or child of an unrecovered alcoholic is treating alcoholism although the alcoholic is not his patient. When treating the alcoholic and/or the family, the physician should utilize all resources of the state or local alcoholism programs for information, education and counseling. Referrals may be made to Al-Anon, the group for family members, which provides help and understanding for the next of kin. It is just as vital in this recovery process as Alcoholics Anonymous, which is generally recommended for the patient.

Treatment of alcoholism without the involvement of the family and long-range recovery has little chance of success. This association recommends that its members assume the responsibility of setting up a structured program of education and therapy for the patient's spouse and family. If needed services cannot be secured, guidance literature should be given the patient and family members. This material may be secured from the State Department of Mental Health or local alcoholism programs and should be available in every physician's office.

Eight alcoholism information centers and three alcoholic treatment facilities have been established in West Virginia under the auspices of the Division of Alcoholism and our State hospitals, West Virginia Department of Mental Health. Physicians in areas served by these information centers and treatment facilities are urged to utilize these services. Physicians in other areas are urged to take the initiative in developing needed community services and facilities.

Physicians, as well as other disciplines, should try to look at the progress that can be made with alcoholics rather than accepting a poor prognosis as is often given in the case of alcoholism. The term "alcoholism" should be used without embarrassment or judgment in conversation with the patient and family. The need for total abstinence as a prerequisite for recovery should be firmly stated to the patient and family. In the same manner the physician may instruct the family that his services to the patient are helpful to the degree that the family together with the patient is willing to accept education and therapy from outside sources and enter cooperatively in the treatment which should continue for a period of two or three years if lasting results are to be anticipated.

In order to accomplish any degree of success with the treatment of this problem, it is necessary that ed-

ucational programs be enlarged, methods of case finding and follow-up be ascertained, research be encouraged, and general education to an acceptance toward these sick people be emphasized. Medical schools should be encouraged to have students take a more active part in learning more about the many facets of alcoholism, including medical, phychiatric, psychological and social.

Symptoms of Alcoholism

Prodromal Stage

(1) Abnormal drinking behavior both in quantity and attitude, go beyond their group.
(2) Blackouts—loss of memory of the night before.
(3) Gulping and sneaking drinks.
(4) Severe and chronic hangover.

Critical Stage

(1) Loss of control—can't leave it alone.
(2) Use of alibis and excuses to justify drinking habits.
(3) Early morning eye-openers to cure hangover.
(4) Changing the pattern—trying wine or beer temporarily.
(5) Solitary drinking—anti-social behavior.
(6) Loss of friends—jobs.
(7) Medical aid sought.

Chronic Stage

(1) Benders—several day drunks.
(2) Tremors.
(3) Protecting supply—hiding bottle.
(4) Unreasonable resentments.
(5) Nameless fears and anxieties.
(6) Collapse of alibi system.
(7) Surrender process.

Scientific Sections Install New Officers

Several scientific associations, sections and societies affiliated with the West Virginia State Medical Association installed new officers during the 100th Annual meeting of the Association at The Greenbrier. They include:

West Virginia State Society of Allergy—Dr. William L. Neal of Huntington, President; Dr. Grover C. Hedrick, Jr., of Beckley, Vice President; and Dr. Merle S. Scherr of Charleston, Secretary-Treasurer.

Section on Pediatrics—Dr. Forest A. Cornwell of Beckley, Chairman; and Dr. Emma Jane Freeman of Charleston, Secretary-Treasurer.

Section on Urology—Dr. D. Franklin Milam of Morgantown, President; Dr. Harold N. Kagan of Huntington, Vice President; and Dr. Michel A. Glucksman of Elkins, Secretary-Treasurer.

Section on Orthopedic Surgery—Dr. Arthur A. Abplanalp of Charleston, President; Dr. John P. Griffith, Jr., of Wheeling, Vice President; and Dr. William R. Barton of Wheeling, Secretary-Treasurer.

Section on Neurology, Neurosurgery and Psychiatry—Dr. Thomas S. Knapp of Charleston, President; Dr. Thomas J. Holbrook of Huntington, President Elect; and Dr. Miroslav Kovacevich of Charleston, Secretary.

Dr. Maynard P. Pride of Morgantown, the newly elected Vice President of the Association, greets a well-wisher during the reception honoring officers.

West Virginia Radiological Society—Dr. Ilona D. Scott of Beckley, President; Dr. Andrew W. Goodwin II of Charleston, Vice President; and Dr. George G. Green of Morgantown, Secretary-Treasurer.

West Virginia Obstetrical and Gynecological Society—Dr. Daniel Mairs of Charleston, President; Dr. Robert Greco of Morgantown, Vice President; and Dr. A. J. Villani of Welch, Secretary-Treasurer.

West Virginia Society of Anesthesiologists—Dr. Norman W. B. Craythorne of Morgantown, President; Dr. Logan W. Hovis of Parkersburg, Vice President; and Dr. Allen E. Yeakel of Morgantown, Secretary-Treasurer.

Section on Surgery—Dr. Alvin L. Watne of Morgantown, Chairman.

Section on Internal Medicine—Dr. George A. Curry of Morgantown, Chairman.

Physicians from 18 States Attend Annual Meeting

Physicians from 18 states and one foreign country were in attendance at the 100th Annal Meeting at The Greenbrier in August. Registration records revealed that physicians traveled to White Sulphur Springs from as far as England, California, Massachusetts and Florida. Physicians also were registered from the following states:

Louisiana, Ohio, Pennsylvania, District of Columbia, Indiana, Tennessee, Virginia, Maryland, Kentucky, Illinois, New York, Oregon, Texas, Michigan and Nebraska.

Mercer County Symposium In Bluefield

Five physicians will present papers at a Symposium on Diabetes, which will be held at the West Virginian Hotel in Bluefield, November 1-2.

The program is sponsored by the Mercer County Medical Society, the Diabetes and Arthritis Control of the U. S. Public Health Service, the Mercer Regional Planning Project for Improved Heart, Cancer and Stroke Service and the West Virginia State Health Department.

Margaret J. Albrink, M. D.

Speakers will include: Dr. John Cassel, Professor of Epidemiology, University of North Carolina School of Medicine; Dr. Jerry Aarons, Instructor in Medicine, University of Pittsburgh School of Medicine; Dr. Jurgen Steinke, Clinical Associate Professor of Medicine, Harvard University School of Medicine; Dr. Clayton Kyle of the University of Pennsylvania School of Medicine; and Dr. Margaret J. Albrink, Professor of Medicine, West Virginia University School of Medicine.

Application has been made to the American Academy of General Practice for accreditation.

The program will begin at 1 P.M. on Wednesday, November 1, and will conclude at noon the following day.

There is no registration fee, and nurses, dieticians, technicians, public health personnel and others are invited to attend as well as physicians.

Additional information may be obtained by writing to Dr. Upshur Higginbotham, St. Luke's Hospital, Bluefield, West Virginia.

The "Yellow Birds"—so-named because of their colorful miniskirt costumes—greet Dr. Richard E. Flood of Weirton, President of the Association, at the Exhibit Center door. These pretty young ladies—Mrs. Sandy Lockhart (left) and Mrs. Donna Neville, both of White Sulphur Springs—were employed by a research firm to help analyze attendance at the exhibits. Mrs. Neville is detaching a code number from behind the ribbon on Doctor Flood's identification badge.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1967

Oct. 2-6—ACS, Chicago.
Oct. 5—Rural Health Conf., Jackson's Mill.
Oct. 5-7—Assn. of Am. Phys. & Sur., Houston.
Oct. 12—Bluefield Sanitarium Seminar, Bluefield.
Oct. 19-21—Va. Medical, Alexandria.
Oct. 20-24—Am. Heart Assn., San Francisco.
Oct. 21-26—Am. Acad. of Ped., Washington.
Oct. 25-28—Cong. of Neurological Sur., San Francisco.
Oct. 29—Am. Assn. of Oph., Chicago.
Oct. 29-Nov. 3—Am. Acad. of Oph. and Otol., Chicago.
Oct. 27-29—Potomac-Shenandoah PG Institute, Martinsburg.

Nov. 9-11—Sou. Thoracic Surg. Assn., Dallas.
Nov. 13-16—Southern Medical, Miami Beach.
Nov. 16-19—Nat. Soc. for Crippled Children & Adults, Los Angeles.
Nov. 25-26—Am. Col. of Chest Phys., Houston, Texas.
Nov. 26-29—AMA Clinical Meeting, Houston, Texas.
Nov. 29-Dec. 3—Am. Med. Women's Assn., Atlanta.

Dec. 2-7—Am. Acad. of Dermatology, Chicago.
Dec. 4-6—Sou. Surgical Assn., Hot Springs, Va.

1968

Jan. 17-18—Am. Rheumatism Assn., Baltimore.
Jan. 20-25—Am. Acad. of Orthopaedic Surgeons, Chicago.
Jan. 29-31—Soc. of Thoracic Sur., New Orleans.

Feb. 3-7—Am. Acad. of Allergy, Boston.
Feb. 6-10—Am. Col. of Radiology, Chicago.
Feb. 23-24—ACP Regional, Cincinnati.
Feb. 28-March 3—Am. Col. of Cardiology, San Francisco.

March 18-20—Am. Acad. of Ped., Atlanta.
March 24-29—Am. Col. of Allergists, Denver.
March 29-30—AMA Nat. Conf. on Rural Health, Seattle.
March 29-31—Am. Soc. of Int. Med., Boston.

April 1-5—ACP, Boston.
April 7-11—Am. Assn. of Neur. Surg., Chicago.
April 16-19—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 17-19—Maryland Medical, Baltimore.
April 22-24—Am. Assn. for Thoracic Surg., Pittsburgh.
April 22-25—Am. Col. of Ob. & Gyn., Chicago.
April 22-27—Am. Acad. of Neurology, Chicago.
April 25-26—Am. Hosp. Assn., Hollywood, Fla.

May 1-2—Am. Ped. Soc., Atlantic City.
May 7-8—Assn. of Am. Phys., Atlantic City.
May 12-17—Am. Psy. Assn., Boston.
May 13-16—Am. Urological Assn., Miami Beach.
May 14-17—Ohio Medical, Cincinnati.
May 19-22—Nat. TB Assn., Houston.
May 23-25—Am. Gyn. Soc., Hot Springs, Va.

June 15—Acad. of TB Phys., San Francisco.
June 15-16—Am. Diabetes Assn., San Francisco.
June 16-20—Am. Col. of Chest Phys., San Francisco.
June 16-20—Am. Col. of Preventive Med., San Francisco.
June 16-20—AMA, San Francisco.
June 20-22—Am. Med. Women's Assn., San Francisco.
June 26-27—Am. Geriatrics Soc., New Orleans.

Aug. 22-24—101st Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.

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A study being conducted by the Department of Otolaryngology, Greater Baltimore Medical Center is stockpiling evidence that points to the fast action and prolonged relief effected by Triaminic in the treatment of nasal congestion.

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WVU Medical Center
—News—

FIFTY physicians have been appointed to the house staff of West Virginia University Hospital, effective last July 1, for training as interns and residents, according to Hospital Director Eugene L. Staples.

The new residents, their hometowns and specialties are as follows:

Otolaryngology—Dr. Phillip Andrews, Roanoke, Virginia; and Dr. Phillip Mathias, Mathias; orthopedics —Dr. Thomas Altizer, Hampton, Virginia; Dr. Dereck Hunter, Ireland; and Dr. Thomas Trainer, Portland, Oregon; urology—Dr. Lionel Nair, Madras, India.

Medicine—Dr. Charles Jacobson, Minneapolis; Dr. Stanleigh Jenkins, Washington, D. C.; Dr. Douglas Jewson, Minneapolis; Dr. Robert Lesnock, Washington, Pennsylvania; and Dr. Berry Smith, Charles Town.

Pathology—Dr. Warren R. Pistey, Bridgeport, Connecticut; and Dr. Robert S. Salisbury, New York City; general surgery—Dr. Yet Sim Tan, Minneapolis; Dr. David Sutherland, Minneapolis; Dr. Jesus Portela, Rio Piegras, Puerto Rico; and Dr. Pasit Panijayanond, Chicago.

Neurosurgery—Dr. James R. Dollison, Dayton, Ohio; anesthesiology—Dr. Ildefonso A. Campomanes, The Philippines; Dr. William E. Christian, Huntington; Dr. Patricia M. Gregg, Morgantown; and Dr. Honorio S. Ronquillo, The Philippines.

Pediatrics—Dr. Alexander V. Fakadej, East McKeesport, Pennsylvania; Dr. James R. Gaskell, Ellwood City, Pennsylvania; Dr. Paul J. Jakubec, Weston; and Dr. Robert H. Moore, Alexandria, Virginia.

Radiology—Dr. Clinton L. Rogers, Keyser; obstetrics and gynecology—Dr. Louise Eschenmann and Dr. Alex H. Wanger, Morgantown.

The new medical interns are Drs. John E. Bergstedt Jr., St. Paul, Minnesota; Richard S. Bransford, Ivor, Virginia; Charles W. Caldwell Jr., Dunbar; Lewis V. Campbell Jr., Gallipolis, Ohio; Martha H. Christian, Martinsburg; James C. Cosmides, Wheeling; Miles K Crowder, Decatur, Georgia.

Robert C. Diercks, Minneapolis; James A. Flueck, St. Paul, Minnesota; Nancy J. Jennings, Morgantown; David V. Keith, St. Paul, Minnesota; Carole S. Kerr, Morgantown; Harry M. Lowell, Cadillac, Michigan; Anthony J. Oliverio, Fairmont.

Gerald A. Ravitz, Verona, New Jersey; Robert Schneck, Minneapolis, Minnesota; Robert J. Selvo, Norwood, Minnesota; Rutherford C. Sims, Morgantown; Jeffrey S. Schultz, Shepherdstown; and Nancy S. Wanger, Martinsburg.

• Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.

Journal Publishes WVU Papers

A national monthly medical journal, *CUTIS, Cutaneous Medicine for the Practitioner,* devoted its July issue almost completely to original articles and other contributions from physicians of the WVU School of Medicine.

Dr. William A. Welton, Chairman of the Division of Dermatology and a member of the magazine's Board of Editors, was guest editor, and a guest editorial was written by Dr. Clark K. Sleeth, Dean of the School.

WVU contributors included Drs. L. Alan Wright, Grover R. Tompkins, Paul Davidson, Margaret J. Albrink, Wilma Reinheimer, John B. Harley, Vicente Anido, John E. Jones, Edmund B. Flink, E. Schrae LaPlante, Ernest W. Chick, Louis Palmer, Barbara Jones, Enid F. Gilbert and R. S. English. Other West Virginia physicians contributing to the issue were Drs. Harold Saferstein of Wheeling and F. C. Prunty of Parkersburg.

Faculty Appointments

Two new additions to the School of Medicine faculty were announced by Dr. Harry B. Heflin, Acting President of WVU.

Dr. Hiroshi Irisawa of Japan became visiting professor of physiology and biophysics for one year.

A specialist in myocardial physiology, Doctor Irisawa is a native of Tokyo and was graduated in 1947 from Tokyo Jikeikai Medical School. He has done graduate work in biochemistry, physiology and biophysics at Tokyo University, the University of Washington, the University of Leiden in The Netherlands, and at Mary Institute in Paris.

Mr. Wilbert Earl Rankin joined the Division of Otolaryngology as an Assistant Professor of Audiology.

A native of Pennsylvania, Mr. Rankin received his B. S. degree in psychology in 1948, and a master's degree in audiology and speech pathology in 1950 from the University of Pittsburgh. From 1965 until his appointment to the WVU faculty in August, Mr. Rankin was Director of the Speech and Hearing Center at Asheville Orthopedic Hospital in North Carolina.

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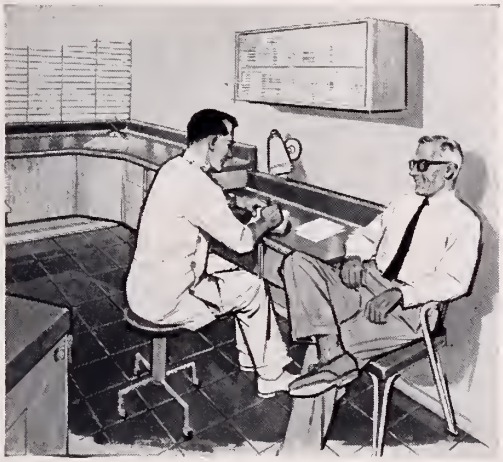

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE American Medical Association strongly opposed a suggestion that doctors' fees under Medicare be based on Blue Shield schedules. The suggestion was made to AMA officials while they were testifying before the Senate Finance Committee on the House-approved Social Security bill which includes amendments to the Medicare and Medicaid programs. Dr. Samuel R. Sherman, San Francisco, Chairman of the AMA's Council on Legislative Activities, said there would be heavy opposition from the medical profession to any change from the present usual-and-customary fees.

Dr. Milford O. Rouse, President of the AMA, gave general approval to the bill passed by the House which, he pointed out, incorporated a number of changes recommended by the AMA. He said further substantive changes better could await the knowledge that one or two more years of experience would bring. However, he urged that consideration then be given to major changes in Medicare Plan B which covers physicians' services.

"We believe it is possible for the Congress, the medical profession and others interested in the subject to develop a new mechanism for delivering medical care to people over 65 that would be consistent with existing private sector mechanisms," Doctor Rouse said.

". . . the Congress realizes it has an open-end program with rising and perhaps uncontrollable costs. We believe that it is possible, and would be eminently practical, to devise another approach that could solve problems which beset Part B. One possibility, for example, might be to substitute for the Part B program a subsidy to all eligible persons, to be used for the purchase of private health insurance. Such an approach could have many advantages.

"The eligible over-65 patient would have a qualified private insurance program of his choice, at no greater expense than he has under the Part B Medicare program; carriers would have a greater responsibility for their own performance with an opportunity to exercise initiative; the physician would continue to deal with his over-65 patient in every respect in the same way as he did before the patient's birthday; and the Congress would have a program with defined costs, and one which would offer the nation a comparison of mechanisms in use to meet the problems of financing health care of the elderly."

Other Points in AMA Testimony

—Beginning with the provisions of Title XVIII (Medicare), the (House) bill does not place the disabled of all ages under Medicare, as had been proposed earlier. We think the House acted wisely in establishing instead, a special Advisory Council to study the problems related to the inclusion of this group and to study the costs involved.

—In addition to the present method of payment for physician's services, the (House) bill provides two new options: either the physician can submit his itemized bill directly to the carrier, in which case payment of 80 per cent of the reasonable charge would be made to him, providing the full charges does not exceed the reasonable charge, or to the patient at his direction; or the patient may submit the itemized bill and be paid 80 per cent of the reasonable charge. From the program's inception, the AMA has urged that the payment be permitted on the basis of an itemized statement of charges.

—Outpaitent hospital diagnostic services would be transferred to Part B of Title XVIII and be subject to the deductible and coinsurance features. This is in keeping with our recommendation to the House Ways and Means Committee that outpatient services be included under Part B, and so remove the administrative difficulty of distinguishing between therapeutic and diagnostic services.

—The bill eliminates both the requirement for initial physician certification for hospitalization of Medicare patients and the requirement for physician certification for outpatient hospital services. The AMA recommended the elimination of initial certification and the subsequent recertification. We continue to recommend the addition of this second step to eliminate the requirement of any certification, since any need in this regard will be satisfied by the work of the medical review or utilization review committee.

—We believe that physicians, having been brought under Society Security, should be accorded the same privilege and opportunity for reaching a fully insured status as was accorded other professional groups when they were included in the program. Accordingly, we urge this Committee to consider the adoption for physicians of an "alternative insured status" similar to that permitted by the amendments of 1954 and 1956 which brought into the program many new groups of people and professional self-employed persons, including lawyers. Further, we urge this Committee to consider amendments that would "drop out" an appropriate number of years for physicians to make their eligibility for cash benefits both equitable and realistic.

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W. E. Wilkinson, M. D.

Mental Health Clinic
Professional Building, Wise, Va.
Pierce D. Nelson, M. D.

Annual Reports *

Committee on Presidential Address

The first reading of the 1967 Presidential Address leaves the impression that, in this case, the written word may be even more impressive than the oral delivery. The diction, the style, the composition and delivery are very definitely Dick Floodian in character. The reward of his experiences, his emotions, his sense of duty, his grasp of responsibility, his recognition of problems and his recommendations for their solution or treatment will leave a definite and lasting imprint upon the minds of those who have listened to, and those who will read his remarks.

He has had the opportunity and the responsibility of presidential service in a year marked by the most radical social, economic and political changes in the history of organized medicine. Of somewhat lesser degree in importance, but albeit requiring decisive consideration and action has been his supervision and direction of the activities associated with the celebration of our hundredth anniversary. When all these tasks are added to the presidential load, it is evident, and generally acknowledged, that only a man of Dick Flood's physical and spiritual stature could meet these responsibilities in a dedicated and successful manner.

His remarks concerning the advent of, and our first year of experience with Medicare, will be approved by the vast majority of his colleagues. They should be in complete agreement with his practical economic contrasts between the fiscal returns to other purveyors of public and governmental services to the oft-times economic sacrifices demanded of our profession.

In this same context the President has again called our attention to the year-old statement of policy by this House of Delegates referable to the "usual and customary charges" as a basis for collection for services rendered to the beneficiaries of all third-party plans. This policy can only reach maximum value and effect through the concerted action of all physicians. Doctor Flood has very concisely described the difference between cut-rate medicine and the charitable care of deserving needy patients.

The President's remarks relative to the increasing shortage of physicians in our State are well taken. Your Committee sincerely recommends for your consideration and action his suggestions regarding a continuing close personal relationship between component medical societies and the medical students from their respective areas.

Doctor Flood's statements regarding the advisability of a permanent liaison committee from medicine, dentistry and the other allied healing professions are certainly worthy of serious consideration by Council and the House of Delegates.

Your Committee heartily endorses Doctor Flood's remarks concerning AMPAC and WESPAC. Our joint struggle against inequity in the relations between organized medicine, the federal government, and all other socialistic elements is certain to extend over the years to come, and our continued financial support is not only desirable, but it is a "must" activity if we are to maintain our deserved status in the social, economic and political phases of contemporary and future existence.

Your President has paid a very gracious and well-deserved compliment to the Women of our Auxiliary for their achievements on local, state and national levels. Your Committee adds their humble thanks to these dedicated women, with the sincere hope for continued success in their particular field.

In closing his remarks, the President expressed his gratitude to the membership for the privilege of serving this Association. It is the Committee's unanimous opinion that a large degree of appreciation and gratitude are due Dick Flood from his colleagues, as was evidenced by your reception of his address. In a parabiblical manner our thoughts might well be expressed as follows—"Well done, thou faithful servant; thou has done well with the talents given thee; now enter ye into the joys and shadows and anonymity of retirement, which are the just dues of all Past Presidents."

Respectfully submitted,

James S. Klumpp, M. D.
Chairman
C. A. Hoffman, M. D.
Frank J. Holroyd, M. D.

*Other annual reports were published in the August 1967 issue of The Journal.

Necrology Report

The following is a list of West Virginia physicians whose deaths have been reported to the West Virginia State Medical Association during the past year:

1966

Aug. 25—W. W. Spelsburg	Clarksburg
Aug. 27—Lester D. Norris	Fairmont
Aug. 28—F. E. Amick	Huntington
Sept. 4—George G. Hodges	Mt. Hope
Sept. 22—Gibson C. Smith	San Diego, Calif.
Oct. 25—John J. Coogle	Fairmont
Oct. 31—James G. Leech	Hinton
Nov. 3—Philip Preiser	Charleston
Nov. 13—E. E. Lovas	Bluefield
Nov. 17—Curtis G. Power	Martinsburg
Nov. 19—John D. Lee	Rock Creek
Dec. 6—E. B. Gerlach	West Palm Beach, Fla.
Dec. 13—J. E. Page	Clarksburg
Dec. 13—Paul P. Warden	Grafton
Dec. 24—Guy R. Post	Fairmont

1967

Jan. 6—William L. Van Sant	Hinton
Feb. 14—Stanley J. Klyza	Washington, D. C.
Feb. 15—M. I. Mendeloff	Charleston
Feb. 23—H. L. Hegner	Wellsburg
Feb. 27—Henry Machmer	South Charleston
Mar. 15—Newman H. Newhouse	Charleston
Mar. 22—Albert D. Kistin	Beckley

Mar. 28—Charles A. Haislip	Grafton
Apr. 6—Edwin Cameron	Clay City, Ky.
Apr. 10—Richard N. O'Dell	Charleston
Apr. 10—John Morgan Foley	Frankford
Apr. 11—Patrick L. Gordon	Belle
Apr. 22—F. Carl Chandler	Ft. Lauderdale, Fla.
Apr. 30—Herbert V. King	Morgantown
Map 23—S. Oscar Fry	Charles Town
June 15—C. Glen McCoy	Holly Hill, Fla.
July 8—Jesse T. Johnson	Hinton
July 25—Ray I. Frame	Madison

Respectfully submitted,

William H. Lively,
Executive Secretary

August 23, 1967.

Comprehensive Book on Drugs Being Prepared

A project to develop the most comprehensive reference book on drugs ever produced by the American Medical Association was launched in March, Dr. Thomas H. Hayes, Director of the AMA Department of Drugs, has announced.

According to present plans, the reference book, which has yet been unnamed, will contain concise, authoritative and impartial information on approximately 1,200 to 1,500 drugs—90 per cent of all nationally advertised single-entity and combination products which are commonly used by practicing physicians.

The book of comprehensive information on drugs will considerably expand the coverage presently given in *New Drugs*, which was introduced in 1965.

The entire departmental staff of 52 persons will be actively involved in gathering and editing information to appear in the reference book, which will take an estimated 18 months to complete, said Dr. John R. Lewis, Associate Director, who is in charge of developing the new publication. It will contain approximately 1,000 pages of information.

Plans call for the reference books to contain 75 chapters, each of which will be divided into three sections—an introductory statement describing actions and uses, adverse reactions and contraindications of drugs in the specific therapeutic category; individual monograph statements on newer single-entity drugs (as is now done in the AMA's *New Drugs*); and complete tabulation of information on older drugs. Extensive appropriately cross-referenced indexes, including therapeutic indications, also will be included.

The tabulated information on older drugs will list names of the individual drugs, their manufacturers; routes of administration and dosage; and give a specific evaluative statement on each product—a key and unique feature of the forthcoming publication.

The reference book is designed to provide the practicing physician with the information he seeks readily and quickly. Members of the Council on Drugs and outside consultants will review each chapter to assure that the information is accurate and current.

Resolutions

The sole resolution offered at the first session of the House of Delegates on Wednesday afternoon, August 23, 1967, was referred to the Committee on Resolutions for study and report back, with recommendations, at the final session on Saturday afternoon, August 26.

Dr. Maynard P. Pride of Morgantown, the Chairman, presided at the meeting of the Committee which was held on Thursday afternoon, August 24.

As recommended by the Committee, the House of Delegates adopted the following resolution:

Resolution No. 1. Treatment of the Chronic Alcoholic in General and Private Hospitals.—By Seigle W. Parks, M. D.

WHEREAS, The Federal Courts have ruled that the chronic alcoholic offender must be treated as a medical problem rather than a criminal; and

WHEREAS, No medical program can succeed without the over-all cooperation of the practicing medical profession; and

WHEREAS, Adequate facilities both private and public, are not available in sufficient numbers;

THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association go on record as encouraging the physicians of our Association to give their active and concerted support to the treatment of the chronic alcoholic and to insist that our general and private hospitals open their facilities in order that the physicians can render this most necessary medical care; and

BE IT FURTHER RESOLVED, That copies of this resolution be sent to all members of Congress representing West Virginia, to Governor Hulett C. Smith, to the Hon. G. Elliott Hagan, Congressman, First District, State of Georgia, and to the West Virginia Hospital Association.

Report of Resolutions Committee

The Chairman of the Committee, Dr. Maynard P. Pride of Morgantown, submitted his report to the House of Delegates at the final session on Saturday afternoon, August 26, 1967. The report follows:

"Your Committee on Resolutions has carefully considered the sole resolution offered before the first session of the House of Delegates on Wednesday afternoon, August 23, 1967.

"This is the first year since the establishment of the Committee that its members have not been presented a number of resolutions which have required a great deal of deliberation. For this, we are most thankful to the members of the House of Delegates for permitting us the time to relax and enjoy the festivities of the Centennial meeting.

"We do assure you, however, that the Committee gave careful consideration to the one resolution offered at the first session on Wednesday.

"Mr. President, we wish to thank you and the members of the House of Delegates for their help and your Chairman personally expresses his gratitude to the members of the Committee.

"In addition to your Chairman, the members of the Committee participating were Drs. Albert C. Esposito, Kenneth G. MacDonald and Mr. William H. Lively, secretary ex officio."

Obituaries

RUSH CARL NEWMAN, M. D.

Dr. R. C. Newman, 77, of Spencer, died in a Parkersburg hospital on August 25.

Doctor Newman was born in Arkansas City, Kansas, attended West Virginia University and received his M. D. degree in 1920 from the University of Cincinnati College of Medicine. He practiced in Akron, Ohio, and Parkersburg before moving to Spencer. He served as Coroner of Roane County.

He was an honorary member of the Parkersburg Academy of Medicine, the West Virginia State Medical Association and the American Medical Association.

Last January 12, he was one of eight members of the Parkersburg Academy of Medicine honored for 50 years of service to medicine.

The widow survives.

* * * *

FORD BARKER ROGERS, M. D.

Dr. F. B. Rogers, a retired Fairmont surgeon, died on September 2 in a Fairmont hospital following a brief illness. He was 86.

Doctor Rogers was born in Missouri and attended Kansas University. He received his M. D. degree in 1905 from the Northwestern University Medical School.

He was an honorary member of the Marion County Medical Society, the West Virginia State Medical Association and the American Medical Association. He had practiced in Fairmont for 37 years before retiring about 12 years ago.

Survivors include the widow, Mrs. Anna Showalter Rogers; one son, Ford B. Rogers, Jr., of Orlando, Florira; and six grandchildren.

Medical Aspects of Sports Program Announced

The program has been announced for the Ninth National Conference on the Medical Aspects of Sports, which will be held on November 26 in Houston, Texas, in conjunction with the AMA Clinical Meeting.

The sessions will be held at the America Hotel. There will be discussions of clinical problems in athletics, quackery in sports, the Olympics and the American Athlete, specialized sports and the prevention of knee injuries.

The meeting, sponsored by the AMA's Committee on the Medical Aspects of Sports, is open to physicians, athletic directors, coaches, trainers and other interested individuals.

Additional information may be obtained by writing to the Committee on Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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HARRISON

The annual Membership Tea of the Woman's Auxiliary to the Harrison County Medical Society was held on September 7 at the home of Dr. and Mrs. Karl A. Dillinger of Clarksburg.

Honor guests were Mrs. Rupert W. Powell of Fairmont, President of the Woman's Auxiliary to the West Virginia State Medical Association; and Mrs. Robert G. Janes, also of Fairmont, Third Vice President of the Auxiliary.

Mrs. Powell said the Auxiliary's theme for the year will be "Allies of Physician Husbands." She also outlined plans for the year's activities.

Three new members of the County Auxiliary were introduced. They are Mesdames Frederick A. Spencer, William N. Walker and Roland Ormsbee.—Mrs. Robert D. Hess, Publicity Chairman.

★ ★ ★ ★

KANAWHA

The Woman's Auxiliary to the Kanawha Medical Society held a coffee in September at the home of Dr. and Mrs. James H. Walker in Charleston.

Mrs. J. L. Mangus, the President, introduced new members of the Auxiliary. They are Mrs. R. S. Birckhead of Gauley Bridge; Mrs. Douglas Curnutte and Mrs. G. D. Sherrill, both of Charleston; and Mrs. John Vaughan of St. Albans.

Members voted to continue their hearing testing program, clothing chest donations, hospital tours for students, special projects contributions and membership in the Community Council of the Kanawha Valley. —Mrs. H. A. Jackson, Publicity Chairman.

Symposium on Trauma

A Symposium on the Management of Trauma and Disaster Medical Problems will be held at the Carillon Hotel in Miami Beach, November 10-11, under the sponsorship of the Committee on Disaster Medical Care and the Council on National Security of the American Medical Association.

Registration fee of $20 will be charged.

Additional information may be obtained by writing to the Committee on Disaster Medical Care, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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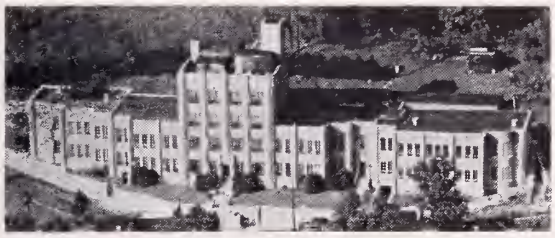

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Book Reviews

RESPIRATORY PHYSIOLOGY—By N. Balfour Slonim, M. D., Ph. D., Director, Pulmonary Function Laboratory, General Rose Memorial Hospital, Denver; John L. Chapin, Ph. D., Assoc. Professor, University of Maryland. The C. V. Mosby Company, Saint Louis. 1967. Illustrated. Pp. 199. Price: $8.75.

This book was designed primarily for the medical student, but should prove of equal interest to the practicing physician and the clinical physiologist. It is written in a simple and clear language, and yet it contains the essence of what is currently known about the fundamentals of respiration.

A great deal of quantitative information is available about the respiratory interface with the environment. Accordingly, the subject as currently taught in most medical schools is based upon precise physical laws and couched in mathematical language. The authors demonstrate their awareness of this modern trend while maintaining a realistic and readable exposition.

Important areas of basic science are reviewed, such as the gas laws, respiratory exchange ratios, mechanics of breathing and diffusion of gases across membranes. New information, in the form of electromicrographs, on the structure of the alveolar-capillary region is included. The chapter on "pH homeostasis" is particularly well written. This subject is of utmost importance in understanding the body economy, and in formulating a rational approach to therapy in acid-base derangements. The last three chapters on regulation, various environments and clinical evaluation are standard and useful. The questions and problems, and the glossary, are valuable additions—Michael F. Wilson, M. D.

PG Course on Strokes

The American Rehabilitation Foundation will conduct a postgraduate course in "New Concepts in Problems of Completed Stroke" on January 19-20 in Minneapolis.

The course will feature bedside teaching, using stroke patients. The American Academy of General Practice has approved the program for 16 hours of credit. Tuition is $50.

Information may be obtained from Dr. Thomas P. Anderson, Kenny Rehabilitation Institute, 1800 Chicago Avenue, Minneapolis Minnesota 55404.

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A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $5.00 postpaid.

ACP Schedule of Courses For 1967-68

The American College of Physicians' postgraduate course schedule for the remainder of 1967-68 is as follows:

Oct. 2-6—"Clinical Cardiology," Loma Linda, California.

Oct. 9-13—"Renal Diseases and Fluid and Electrolyte Balance," Seattle.

Nov. 15-18—"Neurologic Aspects of Internal Medicine," Durham, North Carolina.

Nov. 27-30—"Medical Genetics," Ann Arbor, Michigan.

Dec. 4-8—"Radio-Isotopes and Nuclear Radiations in Medicine," Berkeley, California.

Dec. 11-15—"Advances in Medical Oncology," Houston, Texas.

Jan. 15-19—"Neurology and the Internist," Miami Beach.

Feb. 5-9—"Psychiatry and the Internist," Los Angeles.

Feb. 19-23—"Intensive Care Units," Cincinnati.

Feb. 28-Mar. 2—"Hypertensive Cardiovascular Diseases: Mechanisms and Treatment," Montreal.

Mar. 14-16—"The Clinical Selection of Patients for Cardiac Surgery," Rochester, Minnesota.

Mar. 18-22—"Psychiatry and the Internist," Albany, New York.

Mar. 27-30—"Current Concepts in Physiology of Respiration, Circulation and Electrolyte Metabolism," Boston.

Apr. 22-26—"Clinical Endocrinology — Recent Advances in Diagnosis and Treatment," Rochester, Minnesota.

May 12-15—"Frontiers in Gastroenterology," Philadelphia.

May 20-24—"The Prevention and Early Detection of Disease in Clinical Practice," Philadelphia.

May 27-31—"Auscultation of the Heart," Philadelphia.

June 10-14—"Basic Principles in Internal Medicine—1968," Iowa City, Iowa.

June 17-19—"Intensive Care Units," Denver.

June 19-21—"Infectious Diseases—Mechanisms and Manifestations," Baltimore.

Tuition fees include $60 for each course for ACP members and $100 for nonmembers.

Additional information may be obtained by contacting Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania.

Utilization Review Conference In Houston, Nov. 25

The Second National AMA Conference on Utilization Review will be held on Saturday, November 25, at the Shamrock Hilton Hotel in Houston, Texas.

Physicians wishing to attend the conference should inform the Department of Hospitals and Medical Facilities, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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A doctor, well established in a practice he has maintained for 20 years, finally gets the opportunity to take his wife on their dream tour of Europe. They will be in Switzerland in July. He wonders if there will be any medical meetings he can attend in Switzerland during their visit. He writes to the Archive-Library for information.

A general practitioner has a patient, a 17-year-old girl, who is planning to attend a year of school in Guatemala. She is a potential surgery patient. He is concerned about the type and quality of medical service available in the region. He writes to the Archive-Library for help.

You could be any one of these AMA members who benefit from the services of the AMA Archive-Library, just one dividend for your AMA membership. The Archive-Library services to members include conducting medical literature searches and compiling bibliographies free of charge. Another available aid of great value, the Library's photocopy service, is also free to you. Any article from any journal to which the Library has access can be copied and sent to you for your files.

The Library handles from 1,500 to 1,800 requests for information and publications from physician members every month.

Questions and requests may range from the treatment of chlorine inhalation or statistics on human longevity to the latest treatment for Scleroderma or Raynaud's Disease to plans for the mass treatment of large numbers of burned patients.

The AMA Archive-Library upholds the traditional role of the medical library as an adjunct to the postgraduate education of the physician in practice, but it is even more than a library. It is a complete information center.

As a national medical society library, the Archive-Library is able to provide services not normally available on the local level. A more complete collection of materials allows the Library to supplement local library service. In addition, several special subject collections cover thoroughly such topics as international health, history and the sociology and economics of medicine. The AMA's collection on the sociology and economics of medicine is the best in the world. It contains almost all the English language publications and includes opinions reflected in mass media as well as in scholarly works.

At the core of the Library is a collection of current medical publications. Today, 2,200 journals are received on a regular basis. This is twice the number contained in any average medical school library. These represent all the major publications in medicine and the allied sciences. In addition to the periodicals, the

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Library contains 40,000 books. This makes the Archive-Library one of the most complete current medical libraries you will find any place.

Of course your needs and requests determine the Library's content. The quantity and type of periodicals and reference books contained in the Library are guided by your requirements and those of the AMA staff. Perhaps the one thing above all others which sets the AMA Medical Library apart and makes it a true information center is the availability to the Library staff of a unique resource unavaliable at many other medical libraries—the professional staff members of the AMA's 20 scientific departments.

"The professional staff is here and we can use them," Susan Crawford, director of the Archive-Library, says. "Few other libraries have this type of consultation available. When a doctor writes to us and wants medical opinion or judgment, his question is referred to a consultant on the AMA staff, or to one of many specialists in the country, through the Questions and Answers Department of JAMA."

Such referrals are made in numerous areas such as medical physics, cardiology, psychiatry and drug therapy. Physicians on the AMA staff evaluate information for you before it is ever delivered.

For example, a question on drugs which requires clinical and pharmacological judgment is routed to the AMA's Department of Drugs. The staff in that department can research all available material on the subject and isolate the exact information you need.

The 26 members of the Archive-Library staff will go to great lengths to give you the information you need, and they are fully qualified to do so. They are especially trained to communicate with physicians—they speak your language. Half of the staff have graduate degrees in various areas and many have two masters degrees, one in library science and another in a chosen field such as economics, history or the biological and social sciences.

If you are a history buff, one of the more interesting areas of the Library is the Archive Section which houses documents and artifacts on the history of American medicine and the AMA. If you are at all interested in the progress of organized medicine, in the AMA or in tracing your ancestry or doing other historical research, the Achives hold a wealth of information for you.

The Library is always improving and enlarging its facilities. The last addition to the services was the International Health Section which has made it possible for all of the Library services to follow you, as a member of the AMA, wherever you go, whether it be the remote mountain stretches of West Pakistan, the rain forests of Brazil or a center of civilization such as Paris.

Any of the services of the Archive-Library are available to you by mail, telephone (312-527-1500) TWX (910-221-0300), telex (254-020) or in person. Library hours are 8:30 a.m. to 4:45 p.m. Monday through Friday.

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References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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NOVEMBER
1967

Vol. 63 No. 11

The
WEST VIRGINIA
Medical Journal

Official Organ of the West Virginia State Medical Assaciatian

Box 1031 Charleston, W. Va. 25324

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50c per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

Member 1967

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The West Virginia Medical Journal

Vol. 63, No. 11 November, 1967

The Challenges of the Century*

Milford O. Rouse, M. D.

I am happy to bring the sincere congratulations and commendations from the others of the 215,000 members of the American Medical Association and the 90,000 members of the Woman's Auxiliary to the American Medical Association, to the fine physicians and their wives of the West Virginia State Medical Association on the significant occasion of the observance of your first century of service. Yours is a record of unusual achievements, a record of accomplishments of which you can be justly proud, a wonderful heritage for you to leave for those who shall carry on, a wonderful inspiration as you face the challenging horizons and opportunities of the next century, particularly in the first few decades in which you and I will be active participants.

Among the records of your first century of service, I would like to stress several items. First, you have an unusually high percentage of active AMA members from the good state of West Virginia. A number of you are serving on AMA Councils and Committees, and I sincerely believe that others of you will be called to service on such groups in the coming years. You have a capable, dedicated fulltime staff under the leadership of William H. Lively. You have one of the outstanding monthly medical journals in the country. Your Woman's Auxiliary is not only high in percentage of members but every year receives awards for successful and devoted activity, particularly in the field of gifts to AMA-ERF. You have an excellent medical school whose dean and faculty are sincerely interested in your state organization, and which has an active chapter of the Student American Medical Association. You have an active WESPAC in your good State with evident activity at this particular meeting. You have several chapters of the American Association of Medical Assistants, a fine group of ladies who are among our greatest allies in serving the public. Above all, you have shown numerous instances of outstanding civic service by physicians serving as participating citizens.

The Author

- **Milford O. Rouse, M. D., Dallas, Texas, President, American Medical Association.**

State Suited to Meet Challenge

As I have had the privilege of visiting your good State yesterday and today, in all sincerity, I feel that West Virginia is an ideal environment to meet the challenges of the immediate decades ahead. You have capable, dedicated medical manpower. You have a cooperative citizenry. You have an unusually complete range of economic states, from the underprivileged to those of substantial independence in which to carry out all types of health care services. Above all, you give evidence of ample material resources. And so I predict for you continued fruitful service to mankind in your good State.

Among the challenges facing you in West Virginia and the rest of us in this country are the following: We must continue to elevate the standards and quality of health care services. We must make adequate health care services available to all citizens, with proper assistance by community and government in instances of demonstrated financial need. We will continue to enlarge and expand the plans of voluntary pre-paid health insurance. Above all, we must —and I believe will—exercise leadership from our own medical profession in thorough health care

*Presented at the First Session of the House of Delegates at the 100th Annual Meeting of the West Virginia State Medical Association in White Sulphur Springs, August 23, 1967.

service surveys in our own communities and then furnish the leadership and implementation in meeting any demonstrated health care deficiencies that might be found. We will continue to participate in voluntary health facility planning. We will meet the challenge of increasing participation in community activity by physicians serving as responsible citizens. How wonderful it is to find that your incoming President, Dr. Richard V. Lynch, Jr., is a member of the City Council in his own community of Clarksburg.

Our system and standards of health care in this country are truly magnificant and yet are not perfect, which is in itself a challenge to continued action in improvement. One of the most significant actions of the last session of the AMA House of Delegates in Atlantic City in June was the enthusiastic approval of a report on the cost of medical care, which emphasized two items. First, as physicians, we have a definite responsibility to help our patients get the most out of their health care dollars. In the next place, it is incumbent upon us as physicians to increase our own productivity and efficiency.

I am greatly stimulated by the proposal of one of your own members, Doctor Myers, of Philippi, who has the challenging concept of an excellent college of your State giving special training and courses for physicians' assistants. This is a most practical plan, and I trust sincerely it will come to fruition, as it deserves the hearty approval of your State Medical Association and of the American Medical Association.

Boost in AAMA Membership

As I mentioned, I notice with interest and approval that you have several active chapters of the AAMA. This fine group of 12,000 medical assistants constitutes one of our greatest reservoirs of valuable aid, particularly in helping us to build up and maintain the public relations that we should have. I would hope that you would join with me in adding at least 2,000 new members annually to this fine national organization. Your secretaries, receptionists and nurses are probably the best in the world in your estimation, but they can share their experiences and ideas with others. They will benefit from the bulletin of this fine organization and from some special training courses which are offered. I consider one of my best investments is the privilege of paying the membership in the AAMA of my office staff.

Wives Are Partners

And our wonderful wives are truly our partners in many ways but are most valuable to us in carrying on our service to the people of our particular localities. We have assured Mrs. Karl Ritter, President of the Woman's Auxiliary to the AMA and a guest here today, that we physicians will do our part towards helping add at least 10,000 new members to the organization during the current year.

We can profitably stimulate better liaison with the other members of the health team in our respective areas—our dentists, pharmacists, nurses, hospital administrative personnel, research people, and teachers—all who play a significant part in making the health care industry —now third in the entire nation in total number of people engaged. Particularly can we work profitably with our allies in the field of lay health education. Herein lies one of the most stimulating fields of constructive work, both by our medical profession and by our allies. People are basically interested in their own bodies and what can go wrong with them. Health is truly a common denominator, and if we will devote more attention to the basis of preventive medicine, namely giving information and motivation to the average citizen, we will raise health standards in our country infinitely faster and more successfully than by any system of federal health care. Every community can easily stage a health fair with the cooperation of the Auxiliary, of the dentists, pharmacists and hospital personnel, and nurses in our own areas. Health museums are increasing in number in our country, and in Michigan, a healthmobile has demonstrated its practical value. The health journal, "Today's Health," is an ideal gift for newlyweds or for friends at Christmas time.

Liaison with Medical Students

May I add a word about the wonderful opportunity we have as active practitioners to come to show a personal interest in the fine young men and women who are now in our medical schools—our medical confreres of a few years from now. It is wonderful to have an active advisory or liaison committee both from the state medical and the county medical in the territory where a medical school is located, but each of us has the privilege of maintaining a close personal friendship with young men and women who may be in medical school from our respective cities.

Physicians As Active Citizens

One of the greatest challenges before medicine today is for all of us to take advantage of the privilege and the opportunity and the responsibility of working as participating citizens in our respective localities. I can and do belong to my Chamber of Commerce and participate in its committee work. I serve as best I can in the church of my choice. I am a member of the

Optimist Club in my home city. And I would hope that each of us would realize that only as we contribute our part as responsible citizens can we expect our fellow citizens to look to us for advice on health matters, particularly of a community nature.

And, as citizens, we have the privilege and obligation to take an active part in the political activities of our home cities and states, particularly in selecting our national legislators. AMPAC is one of the most practical activities sponsored by American physicians and deserves 100 per cent membership by our medical profession each year. An active program in 1967 is one of the best ways of insuring successes at the polls in 1968. I note with approval that Dr. Blair Henningsgaard, President of AMPAC, is with us at this meeting, and I know you will be interested in seeing that every doctor here is a member of AMPAC and WESPAC before he returns to his home.

Medicare

As physicians, we are often asked about our attitudes toward Medicare. I think we can best characterize our attitude as one of good-humored, vigilant tolerance. We observe Medicare because it is the law of the land, but we still do not endorse it. Upon invitation from the Department of Health, Education and Welfare, we made a number of suggestions in the preparation of the regulations for Medicare, because we are always happy to respond to an invitation from Government or any agency for advice when we are assured of freedom of judgment and freedom of action.

We have taken an active part in making suggestions to the House Ways and Means Committee on specific ways in which the present Medicare law can be made more workable and more equitable. It is a matter of satisfaction to American medicine that the eventual bill on Social Security amendments brought out by the House Ways and Means Committee and overwhelmingly approved by the House last week does show the acceptance of practically all of the suggestions we had made, particularly for a provision whereby an itemized bill will enable a Medicare recipient to be paid just as well as will a receipted bill; a dropping of the requirement for initial physician certification of the need of hospitalization; and assurance of free choice of physician and facility under Title XIX. We were pleased that the House Ways and Means Committee, and subsequently the House, refused to accept the suggestion of the Administration that all of the physically disabled in this country, regardless of age, be brought under Medicare, which would have meant a material increase in the cost of the program. We are still urging some other recommendations that Title XIX provisions may be brought more in line with provisions under Title XVIII. Next week the AMA will testify before the Finance Committee of the Senate, and it is hoped that at that time these additional suggestions will be made.

We feel that very definitely the House has stood firm against expansion of Medicare and has exhibited a commendable concern over the predicted formidable increase in the tax costs of health care through federal government channels.

American medicine has always felt that it is the right of every citizen to have available adequate medical care—the right of access to health, as it were, but it is the individual citizen's responsibility as well as privilege to take the initiative in securing this care, through his own resources primarily, with the financial aid of his community and government in instances of demonstrated financial need. Health cannot be handed to an individual or forced on him, any more than education, the availability of which is also his right.

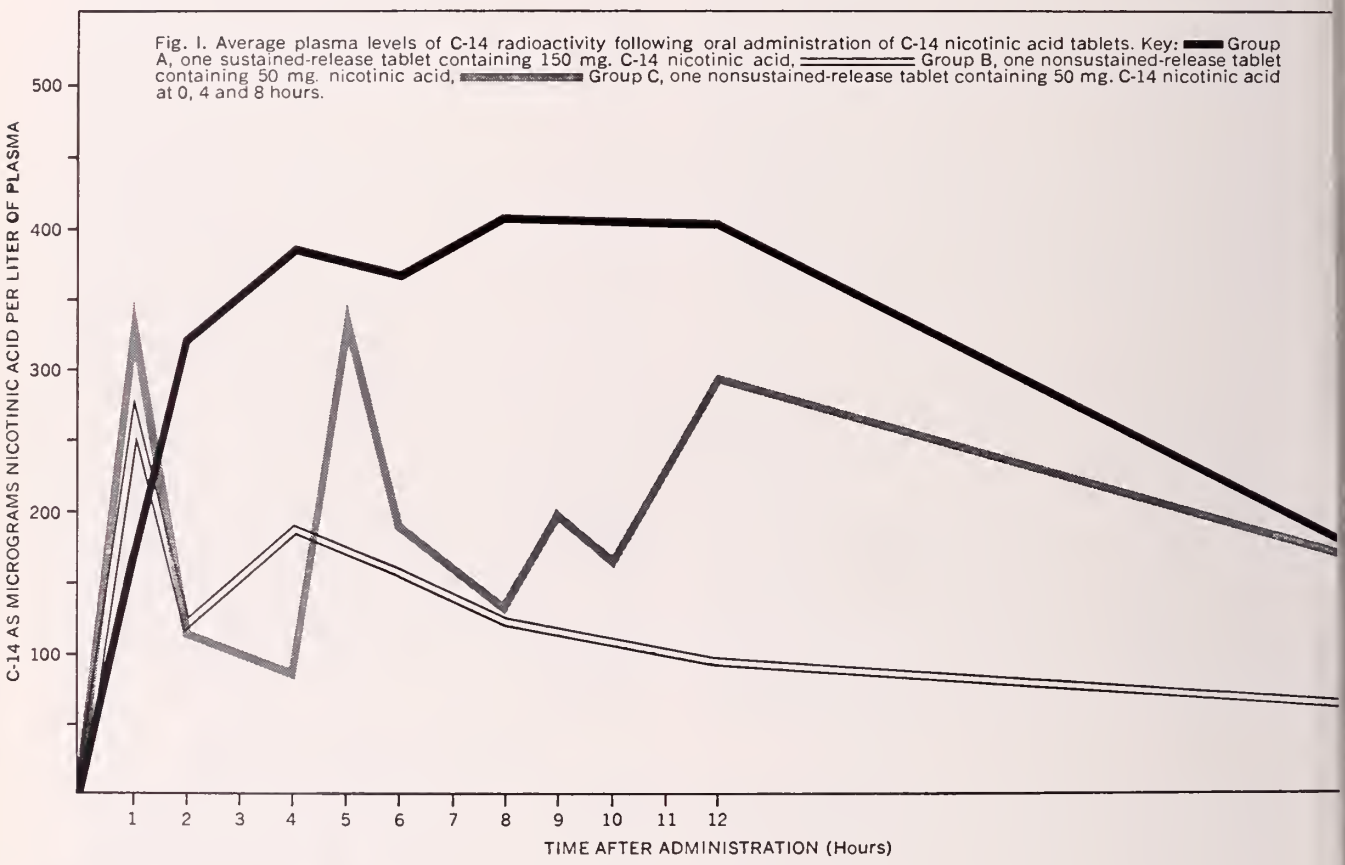
The immediate future truly calls for re-valuation on the part of each of us, a sincere soul-searching as to the capabilities and resources of each of us as individuals as well as groups of physicians. Such re-valuation should result in a more complete development of all resources and capabilities to the end of maximum activity and service.

Participation in Organized Medicine

One of the greatest privileges as well as responsibilities of an individual physician is to participate in his county society, in his state society, and in the activities of the American Medical Association. To do this he needs to keep well informed and it is my sincere hope that every physician will devote that comparatively short time that it will take to review his county bulletin, his state medical journal, the *AMA News* and the *Journal of the American Medical Association.* Your State President will join with the President of the AMA in regular messages on the President's Page which will seek to direct your attention to current developments and to special articles which will mean much to you in serving better your patients in your community.

So again may I congratulate you on your first century of tremendous and commendable accomplishments, and wish for you even broadened areas of happy, fruitful service to West Virginia and to our good country in the decades immediately ahead of us.

Sustained circulatory, respirato and cerebral stimulation for th



(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate signs of senile confusion. Patients become more alert,

ged and debilitated

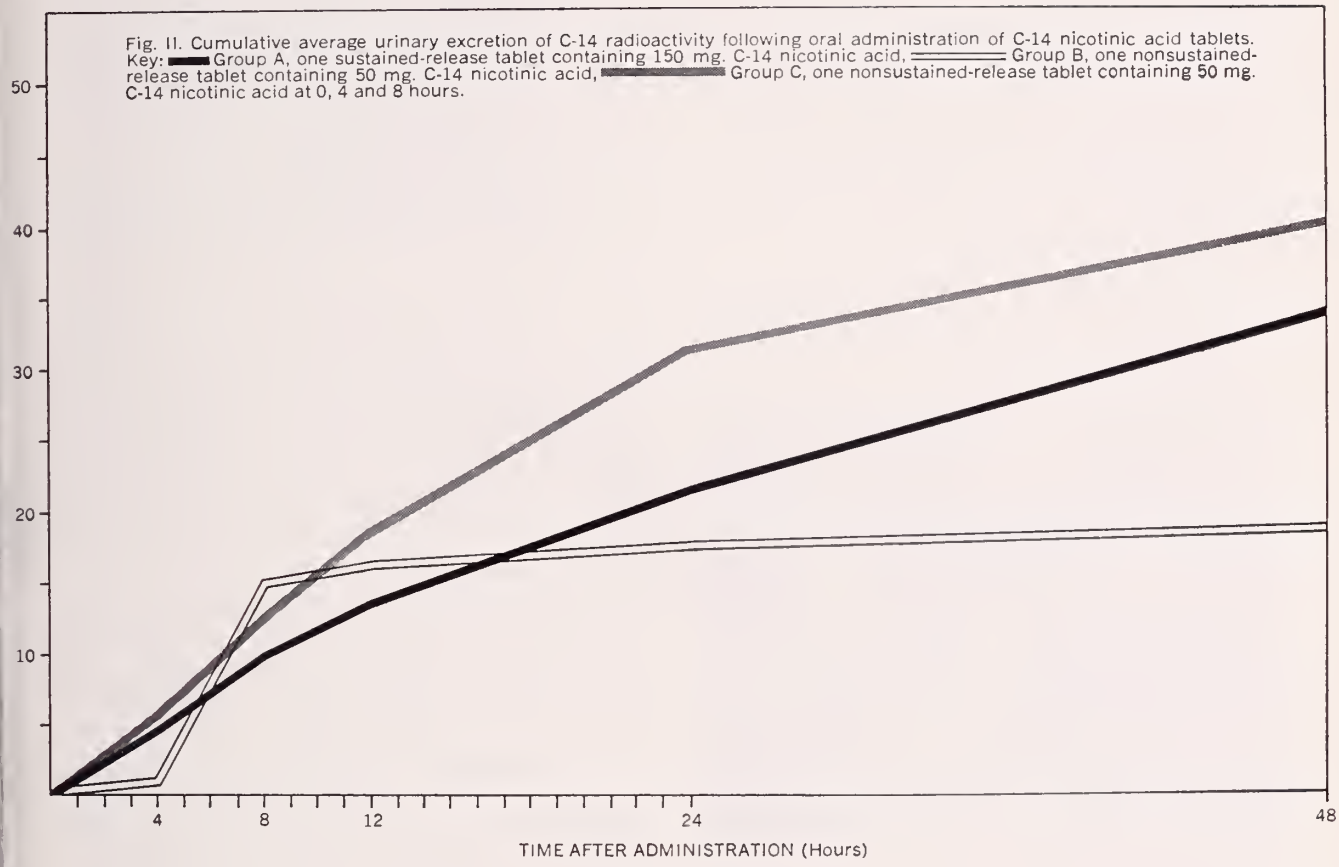


Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

s confused and moody. Personal care, memory, notional stability, social attention improve. Fatigue, athy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will rmit your patients to enjoy the benefits of time-olonged nicotinic acid/pentylenetetrazol therapy, an economical price. Dosage is only one tablet every hours.

ntraindications: There are no known contraindicans.

ecautions: Exercise caution when treating patients h a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Pathogenesis of Drug Induced Thrombocytopenia

Anne Kessinger, M. D., Vicente Anido, M. D., and Rex B. Conn, Jr., M. D.

Drug induced thrombocytopenia is an uncommon disorder and usually receives little concern as the physician writes his score or so of prescriptions each day. This unfortunate complication of therapy with an otherwise safe and effective drug may arise at any time, however, in any type of practice. Recognition of drug induced thrombocytopenia requires, first, knowledge of its pathogenesis so that it may be identified and appropriate confirmatory laboratory tests obtained and, second, knowledge of the classes of drugs which may produce it.

The Authors

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Diagnosis of Thrombocytopenia

The factor common to all cases of drug induced thrombocytopenia and the first indication of the complication is reduction of the number of platelets in the peripheral blood. The average number of platelets in the peripheral blood is 250,000/cu.mm., with a normal range of 150,000 to 450,000. A quantitative platelet count is the most accurate method of detecting thrombocytopenia; significant thrombocytopenia can be recognized, however, merely by examining a peripheral blood film for the presence of platelets. When the platelet count drops to 100,000/cu.mm. definite thrombocytopenia is present. Bleeding disorders, with accompanying clinical signs of petechial hemorrhages and ecchymoses, usually do not occur unless the platelet count is below 60,000/cu.mm. Thus, the appearance of a bleeding disorder during any type of drug therapy demands immediate attention and the physician should obtain the necessary laboratory tests without delay.

Causes of Thrombocytopenia

Several different mechanisms are involved in the production of drug induced thrombocytopenia. Gangarosa, Johnson and Ramos[14] have classified drugs that may produce thrombocytopenia according to the mechanism by which the drug induces the disorder. While this classification is useful for certain purposes, the processes through which many therapeutic agents evoke thrombocytopenia are unknown and such a classification is of limited usefulness to the practicing physician. Crosby and Kaufman[9] have outlined a classification of drug induced thrombocytopenias which divides them into two major groups: those due to increased platelet destruction and those due to decreased platelet production. With some modifications their classification can include also an indication of the pathogenesis of thrombocytopenia. This approach should be of more use to the practicing physician since it is based on the alterations in the patient's blood and bone marrow produced by the offending drug and the required information can be obtained by procedures which are available to all physicians. An additional advantage of the latter classification is that it indicates the probable mechanism of induction of thrombocytopenia and does not limit the detailed pathogenetic study of the thrombocytopenia if specialized laboratory tests are available.

Evaluation of Platelet Production

Evaluation of the patient with thrombocytopenia requires a platelet count of the peripheral blood to confirm and quantitate the platelet deficiency and a bone marrow examination to determine the status of the platelet-producing cells, the megakaryocytes. The megakaryocytes are very large cells with irregularly lobulated nuclei. They contain much cytoplasm which is packed with very fine granules. In the adult they are found in the bone marrow and the lung and sometimes in the spleen, but bone marrow aspiration is by far the easiest method of examining these cells. The megakaryocytes produce platelets by forming numerous bud-like projections on the edge of the cytoplasm, and as these formations break off they are swept away and become the platelets in the peripheral blood. Examination of a bone marrow film reveals whether megakaryocytes are present in normal numbers, increased numbers or decreased numbers. If they are present, the appearance of the megakaryocytes indicates whether or not they

Submitted to the Publication Committee, February 2, 1967.

are producing platelets. The megakaryocyte shown in Figure 1 is actively producing platelets which can be seen breaking off the outer rim of the cytoplasm. The megakaryocyte shown in

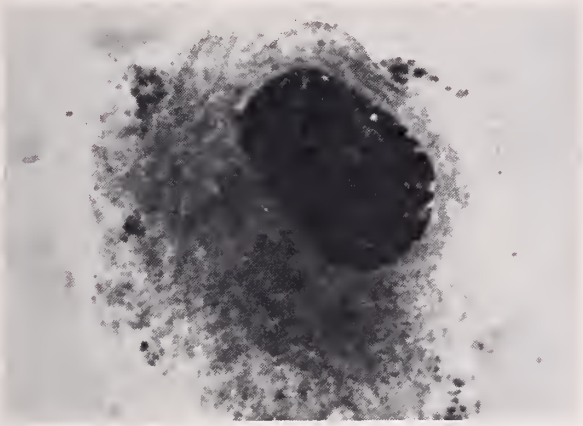

Figure 1: Photomicrograph of a normal megakaryocyte in the bone marrow actively producing platelets. (X 1200)

Figure 2 is not producing platelets, and no budding is seen on the cytoplasmic border. The nonplatelet-producing megakaryocytes should be examined for indications of cellular damage which is suggested by a degenerated fragmented nucleus, absence of normal cytoplasmic granulation or the appearance of vacuoles in the nucleus or cytoplasm (Figure 3).

Classification of Thrombocytopenia

Information obtained from the bone marrow examination will permit placing the morphological findings in one of three groups: 1. The megakaryocytes may appear normal and may be producing adequate numbers of platelets. 2. The megakaryocytes may be present in normal numbers but not producing platelets and may appear damaged. 3. The megakaryacytes may be markedly reduced in number or totally absent. In the first group, thrombocytopenia is secondary to increased platelet destruction with no observable effect on platelet production, while the

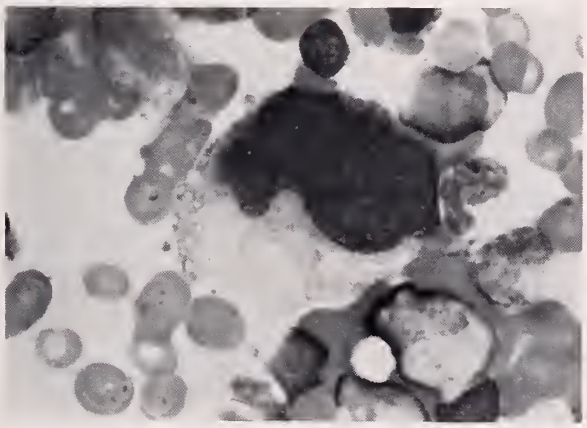

Figure 2: Photomicrograph of a megakaryocyte which is not producing platelets. Small cytoplasmic vacuoles are present adjacent to the cell membrane. (X 1200)

latter two groups represent thrombocytopenia due to decreased platelet production secondary to the effects of the drug upon the megakaryocytes.

Using this information the possible mechanisms responsible for thrombocytopenia may be outlined as follows:

I. Absent or reduced circulating platelets, normal platelet-producing megakaryocytes.
   A. Immune mechanism causing platelet agglutination.
   B. Direct toxic effect on the platelets.

II. Absent or reduced circulation platelets, morphologically damaged or nonplatelet-producing megakaryocytes, or both.
   A. Immune mechanism against megakaryocytes.
   B. Direct toxic effect on megakaryocytes.

III. Absent or reduced circulating platelets, absent or reduced megakaryocytes.
   A. Direct toxic effect on megakaryocyte precursors.
   B. Toxic effect on entire bone marrow.

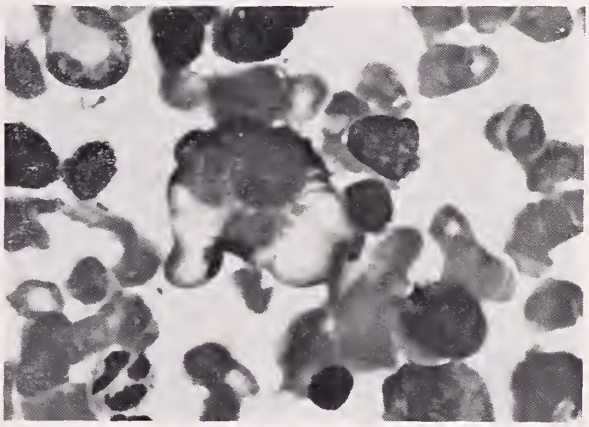

Figure 3: Photomicrograph of a severely damaged megakaryocyte. There is marked degeneration of the nucleus with fragmentation of the nuclear chromatin and almost complete absence of cytoplasmic granulation. No bud formation can be seen. (X 1200)

Table I lists drugs reported to have produced thrombocytopenia, using this classification. Other drugs have been reported to have produced thrombocytopenia but are not included because bone marrow examination was not done, and no conclusions regarding the mechanism of thrombocytopenia could be reached.

Certain drugs appear to have the capability of combining with platelets and stimulating the production of antibodies to the drug-platelet combination. The thrombocytopenia in Sedormid sensitization has been demonstrated by Ackroyd[1] to be due to such a mechanism. Quinidine,[5, 7, 31] quinine,[7,19] sulfamezathine[7] and novobiocin[10] also produce thrombocytopenia through this mechanism. Circulating platelet agglutinins can

TABLE I

I. Absent or reduced circulating platelets, normal platelet producing megakaryocytes.

Sedormid[1]	Ristocetin[14]
Quinidine[5,6]	DDT[18]
Diethylstilbesterol[8]	Prochlorperazine[22]
Novobicin[10]	Sulfapyridine[26]
Sulfamethoxypyridazine[29]	Oxophenarsine Hydrochloride[28]
Chlorpropamide[12]	Sulfanilamide[20]

II. Absent or reduced circulating platelets, morphologically damaged or nonplatelet-producing megakaryocytes, or both.

Digitoxin[4]	Sulfathiazole[25]
Isoniazid[17]	Gold[30, 20]
Sodium Salicylate[24]	Quinidine[6, 31, 5]
Sodium Para-Aminosalicylate[16]	Quinine[7]

III. Absent or reduced circulating platelets, absent or reduced megakaryocytes.

Arsenobenzol[2]	Leg color preparations[30]
Oxytetracycline[3]	Sulphadimidine[21]
Thioridazine hydrochloride[11]	Thiourea[23]
Tridione[13]	Chloramphenicol[27]
Salicylamide[15]	Benzene
Antimetabolites	

be demonstrated in the patient's serum; this requires highly specialized laboratory techniques, however, which are not widely available. The second mechanism which may remove platelets from the peripheral blood without damaging the megakaryocytes is a direct toxic effect on the platelets such as that produced by Ristocetin.[14] In the latter situation the platelets appear structurally altered, and no platelet agglutinins can be demonstrated.

In the situation in which there is marked peripheral thrombocytopenia and damaged or nonplatelet-producing megakaryocytes in the marrow, one of two mechanisms might be responsible for the thrombocytopenia: a direct toxic effect on the cells or an antibody produced against the megakaryocytes. Sodium para-aminosalicylate,[16] digitoxin[4] sodium salicylate[24] and gold salts[20, 30] are among the drugs directly affecting megakaryocytes.

In the last group thrombocytopenia is directly due to markedly diminished or absent megakaryocytes in the marrow, and the condition is easily identified by examination of the bone marrow. It is unusual, however, for a drug to affect only the megakaryocytes in the marrow although oxytetracycline[3] has been reported to produce this type of thrombocytopenia. A much more common finding is a depression of most or all of the developing cells in the bone marrow, and in this situation there is not only thrombocytopenia but leukopenia and anemia as well. Benzene, tridione,[13] salicylamide,[15] chloramphenicol,[27] and antimetabolites such as 6-mercaptopurine may be responsible for such marrow depression.

Combination of Mechanisms

Certain drugs may produce thrombocytopenia through a combination of mechanisms; for example, a combination of platelet agglutinins and an inhibitory effect on the megakaryocytes. Quinidine apparently both stimulates platelet agglutinin formation and prevents release of platelets into the peripheral blood.[31]

Prognosis and Treatment

Generally, drug induced thrombocytopenias in class I in which the effect is directly upon the platelets carry the best prognosis and are the easiest to treat. Since the platelet-producing cells are not damaged, usually the only therapy necessary is withdrawal of the offending drug, and recovery may be expected within a matter of days. Thrombocytopenias in classes II and III are more difficult to treat because platelet-producing cells are damaged or destroyed. Although simply withdrawing the offending drug may be adequate therapy, treatment with adrenocorticosteroids may be necessary. Significant bleeding due to thrombocytopenia should be treated by transfusion with fresh whole blood which has been drawn in plastic containers. A transfusion of platelet concentrate is a highly effective, although temporary, treatment for thrombocytopenia, and many blood banks are able to prepare such concentrates when necessary. Thrombocytopenia of class III usually carries the poorest prognosis, and prolonged vigorous therapy may be necessary. When all of the bone marrow elements are depressed, infection due to leukopenia and bleeding due to thrombocytopenia become complicating factors.

Until more is known about the factors which control platelet production and govern platelet destruction, a more detailed classification than the one above probably is not possible. The proposed classification has been adopted because it permits a practical approach to understanding drug induced thrombocytopenia on the basis of readily available information. It also has the advantages of indicating the probable mechanism of production of thrombocytopenia, gives an indication of the prognosis and suggests the treatment which might be necessary.

Summary

A classification of drug induced thrombocytopenia which is based on bone marrow morphology appears to be most satisfactory because it utilizes information available to all physicians, because it suggests the mechanism through which thrombocytopenia is produced, because it is helpful in arriving at a probable prognosis, and aids in selection of therapy.

*A list of references may be obtained by writing to The Journal.

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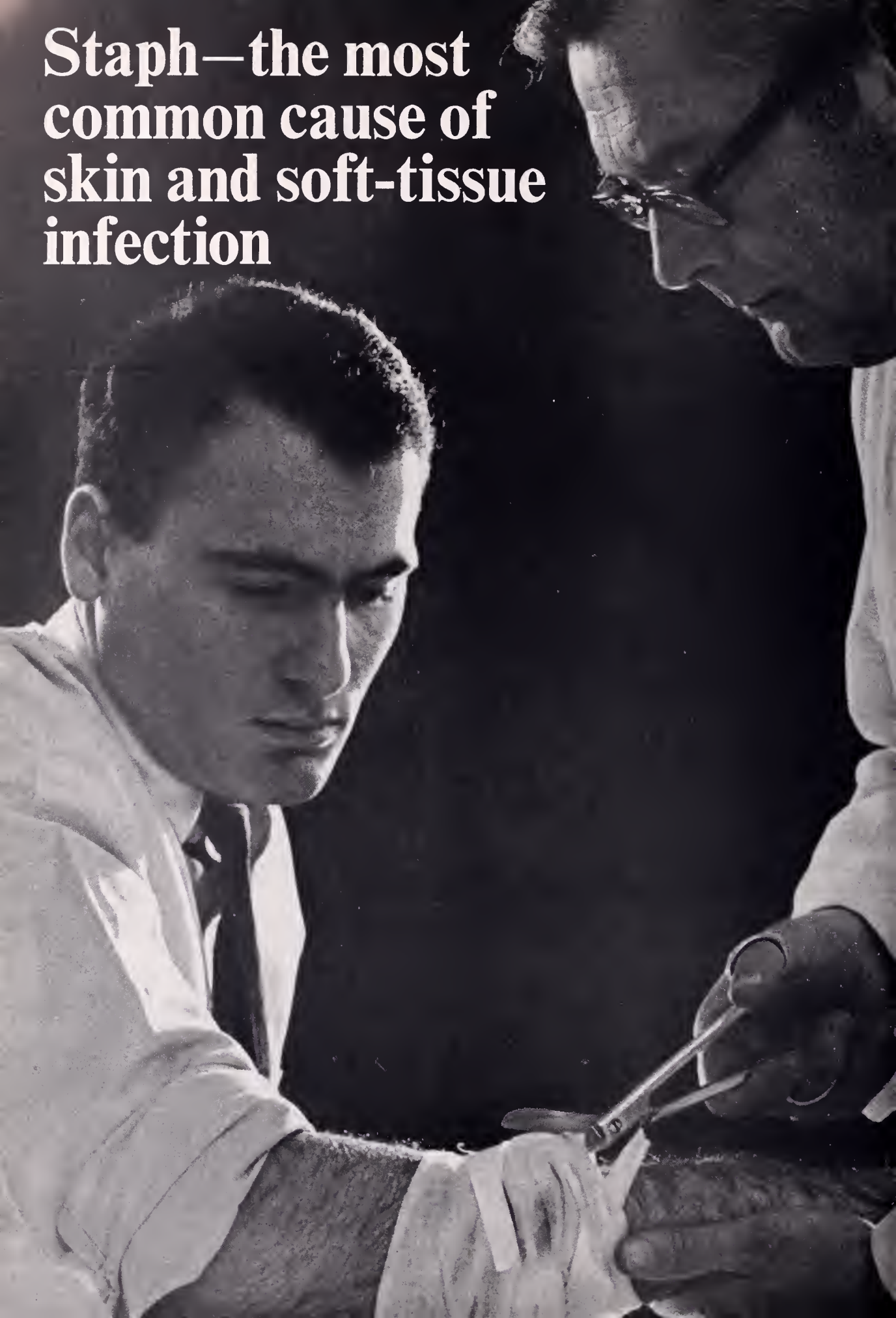

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Staph—the most common cause of skin and soft-tissue infection—also is responsible for many more serious infections, such as pneumonia, osteomyelitis, and septicemia. Often, a seemingly minor skin infection is the source of metastatic spread to deeper structures. When findings on culture incriminate staph as the cause, Prostaphlin (sodium oxacillin) will provide specific effective therapy.

Bactericidal effectiveness. Hardly a staph organism can resist the bactericidal action of Prostaphlin (sodium oxacillin), as shown by a 34-month *in vitro* study. Of all staph isolates tested, 99.5% were sensitive to oxacillin.[1]

Clinically proven. There is a high correlation between these *in vitro* findings and clinical results. Of 610 patients treated with Prostaphlin (sodium oxacillin), 89.8% were reported cured or improved, including those with staph infections resistant to penicillin G.[2] And since resistance does not appear to develop *in vivo,* therapy with oxacillin can be extended when necessary.

Outstanding safety record. Besides being staph-specific and rapidly absorbed—Prostaphlin (sodium oxacillin) has established an outstanding record of safety during five years of widespread clinical use. Continuous high blood levels of oxacillin have not produced toxic effects on kidney function, assuring a significant margin of safety. However, as with all penicillins, the possibility of allergic response should be considered.

Capsules, Oral Solution and Injectable. Prostaphlin (sodium oxacillin) is available in three flexible dosage forms to suit the age of the patient and severity of infection—capsules, an oral solution for pediatric use, and multi-dose vials for injection, I.M. or I.V.

PRESCRIBING INFORMATION: For complete information, consult Official Package Circular. *Indications:* Infections caused by Staphylococci, particularly those due to penicillin G-resistant Staphylococci. *Contraindications:* A history of severe allergic reactions to penicillin. *Precautions:* Typical penicillin-allergic reactions may occur. Safety for use in pregnancy and premature infants is not established. Because of limited experience, use cautiously and evaluate organ system function frequently in neonates. Mycotic or bacterial superinfections may occur. Assess renal, hematopoietic and hepatic function intermittently during long-term therapy. *Adverse Reactions:* Skin rashes, pruritus, urticaria, eosinophilia, nausea, vomiting, diarrhea, fever and occasional anaphylaxis. Rare cases of reversible hepatocellular dysfunction have occurred. Moderate SGOT elevations have been noted. Thrombophlebitis has occurred occasionally during intravenous therapy and leukopenia was noted in two cases. *Usual Oral Dosage:* Adults: 500 mg. *q.4* or *q.6h.* Children: 50 mg./Kg./day. *Usual Parenteral Dosage:* Adults: 250-500 mg. *q.4* or *q.6h.* Children: 50 mg./Kg./day. Treat beta-hemolytic streptococcal infections for at least 10 days. Give oral drug 1 to 2 hours before meals. *Supplied:* Capsules—250 and 500 mg. in bottles of 48. Injectable—250 mg., 500 mg., and 1 Gm. dry filled vial for I.M./I.V. use. For Oral Solution—100 ml. bottle, 250 mg./5 ml. when reconstituted. **A.H.F.S. CATEGORY 8:12.16**

References: 1. Abstracted from *Antibiotic Sensitivity of Staphylococci Studied from November 1962 through August 1965,* reported by Griffith, L.J., Staphylococcus Reference Laboratory, V.A. Hospital, Batavia, N.Y. 2. Data on file, Bristol Laboratories.

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Whipple's Disease: Review of Literature and Case Report

Franklin A. Paul, M. D.

WHIPPLE,[1] in 1907, described a disease process which continues to intrigue and baffle investigators of today. The etiology is still in question. The completeness of his description has not been greatly elaborated on to date. Only a little over 100 cases have been reported. Whipple described anatomical findings consisting of deposits of fat and fatty acids in the intestines and mesenteric lymphatics, and the microscopic appearance of large pale macrophages in the lamina propria of the intestinal tract which did not take up fat stains. Because of the large amount of fat deposition in the intestinal tract, he termed the disease intestinal lipodystrophy.

Black and Schaffer,[3] in 1949, demonstrated that the material within the machophages located in the lamina propria reacted with periodic acid Schiff stain and interpreted it as being glycoprotein. Some investigators[4] believe the primary defect to be an inherited metabolic one localized in the intestinal mucosa, i. e., a cytoplasmic elaboration of an abnormal protein-carbohydrate complex by the cell. Rowlands[5] reported two cases of colonic histiocytosis in children suggesting that Whipple's disease may be an inherited defect remaining silent until adult life. As possibilities for the mechanism of accumulation of the PAS positive material, thought to be a polysaccharide, he suggested that (1) the material may be absorbed from the lumen of the intestinal tract as the result of a defect in the mucosal epithelium, (2) it may be produced by alteration in the ground substance of the lamina propria with subsequent phagocytosis and (3) the histrocytes in the lamina propria may synthesize the accumulated substance themselves. Some authors say that the disease may represent a generalized allergic response to absorption of an abnormal mucin produced by the intestinal tract. With the picture of polyarthritis and polyserositis and the response of the disease to steroids, the possibility of a collagen disease also has been considered.

With the advent of electron microscopy, there have been reported cases[4] of PAS positive cells scattered throughout all organs of the body, giving rise to the thought the disease may be systemic. Spain[6] reported one case of PAS positive pulmonary emboli in Whipple's disease, which may account for its distant manifestations. Chears[7] described "numerous Gram positive, encapsulated, baccilliform bodies in the intercellular spaces and in the macrophages." Because of the production of mucopolysaccharides by bacteria, he concluded that the PAS positive substance within the macrophages could represent "the mucopolysaccharide capsule of the ingested bacteria." Sieracki[8] termed the macrophages S.P.C. cells, or sickle-form particle-containing cells, because of the sickled appearance of the particles within the macrophages. He felt that "they may represent a widespread proliferation by a metabolically aberrant strain of mutant reticular cells." Haubrich[4] felt "if the PAS positive substance occurs in the S.P.C. cells by phagocytosis, one would assume it was first deposited in the tissue by some unknown mechanism, however, the S.P.C. cells occur more often in the absence of extra cellular PAS positive substance. Also if this were an inflammatory reaction with active phagocytosis one would expect to see other cells better known for phagocytosis than just the large histiocytes."

Submitted to the Publication Committee, May 23, 1967.

The Author

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Bacterium Theory Support

To support the bacterium theory, Davis[9] and several other investigators have reported disappearance of the small bacteria as noted by Chears, from the lamina propria shortly after administration of antibiotics.

Gross Pathology

The gross pathologic picture is that of prominent villi of the mucosa of the small bowel, with marked accummulation of fat in the intestine and

mesenteric lymphatics. Microscopically the lamina propria of the small intestine is crowded with dense sheets of pale, foamy macrophages staining with PAS stain.

Diagnosis

The six cardinal diagnostic signs and symptoms of Whipple's disease[2] are migratory polyarthritis, vague abdominal symptoms, diarrhea, cough, weight loss and asthenia. The arthritis precedes the diarrhea by several months or years. The diarrhea and wasting suggest a sprue-like state. The arthritis is not crippling and L. E. preparations and tests for the rheumatoid factor are negative.

For years, Whipple's disease was diagnosed only at post mortem examination and, on occasion, at the operating table, when a patient was explored for vague abdominal complaints. Korsch,[10] in 1938, reported the characteristic PAS staining cell located in peripheral lymph nodes and Puite,[11] in 1955, was the first to diagnose a case by a peripheral node biopsy. Brodoff,[12] in 1959, reported on the use of a peroral small intestine biopsy tube in obtaining a specimen of mucosa from the jejunum for the diagnosis of Whipple's disease. Caravati,[13] reported three cases diagnosed by other means, but all having characteristic PAS staining cells in the rectal mucosa. Caravati,[13] advocated rectal mucosal biopsy as a diagnostic tool in a suspected case.

Treatment

Treatment of Whipple's disease is as controversial a subject as is its etiology. Most investigators suggest the use of ACTH alone or in combination with antibiotics as the treatment of choice. Plummer[14] reported one case refractory to cortisone, however, responding to ACTH therapy with an apparently complete remission. Cortisone is thought by some to be successful through its action of promoting intestinal absorption and inhibiting inflammatory response and antigen-antibody reaction. The response to ACTH[14] suggests that other corticosteroids in addition to cortisone have an effect on the disease process. In particular, 11-dehydrocorticosterone (Compound A) which experimentally enhances fat absorption, may be responsible for the better response to ACTH. Still other investigators feel that antibiotics are the treatment of choice. Davis[9] reported ten cases treated with a combination of steroids and antibiotics, or steroids or antibiotics alone. No patient had a relapse while on antibiotics, but in two cases there was a relapse while the patient was on steroids only, with recovery on addition of antibiotics. The most frequently used antibiotic is tetracycline; however, penicillin and streptomycin, alone or in combination, have been used.

A case of Whipple's disease is reported[13] in which the diagnosis of Hodgkin's disease was made, the patient receiving x-ray treatment and nitrogen mustard, with some response. Maddock[15] reports a case in which the patient failed to respond to ACTH and cortisone, with rapid deterioration of the patient until I. V. nitrogen mustard was administered as a last resort. The patient responded dramatically, his diarrhea subsided, he gained weight, and remained symptom free for at least six months.

Barua[16] reported on two cases of lymphosarcoma of the small bowel with diarrhea and malabsorption syndrome treated with oxytetracycline, with marked and prompt relief of symptoms. Because of the "similar clinical events and improvement in patients with Whipple's disease following administration of antibiotics, a connecting link between the two conditions has been considered."

The following report may be of interest since it shows a dramatic response to antibiotic therapy alone.

Figure 1. Upper G.I. x-ray. Sixty per cent of the barium was noted in the stomach after six hours, indicating a high degree of obstruction at the outlet.

Figure 2. Small bowel x-ray. There was noted a large, widened and deformed duodenal loop thought to be due to a lesion in the head of the pancreas. In the jejunum and ileum there were noted large edematous-appearing mucosal folds, giving a feathery appearance similar to that seen in malabsorption or sprue.

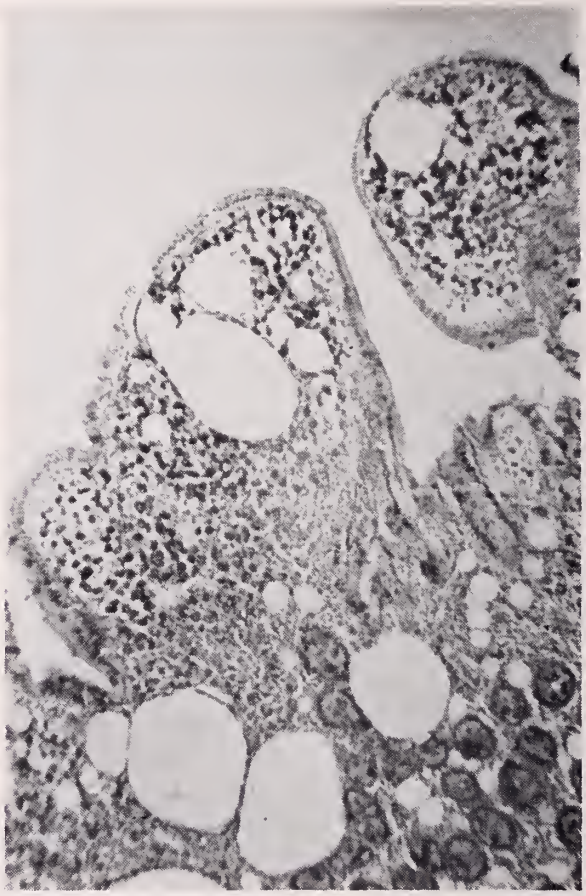


Figure 3. Microscopic section of the jejunal biopsy. The villi were noted to be enlarged. There were many large histiocytes filled with PAS positive material, packed within the lamina propria. Also noted were many fat vacuoles.

Case Report

H.P.I. The patient is a 49-year-old white male admitted to St. Luke's Hospital, Bethlehem, Pennsylvania, on February 2, 1964, with the chief complaints of weakness and weight loss. He had been hospitalized in July of 1963 with the chief complaint of chills. The history at that time was of poor appetite with a 15-20 pound weight loss, nocturnal chills, sweating, weakness and migratory arthritis for five to six months prior to admission.

TABLE 1

Preoperative

Radioactive Fat Study (Triolene I-131)

I. Blood Values

Time in Hrs.	% of dose/Liter	% of dose/total blood volume (estimated volume of 5 liters)
2	1	5—Normal 8 and above
4	1	5—Moderate impairment 5-8
5½	1	5
6½	1	5—Marked impairment below 5

II. Fecal Fat Studies

Time in hours	% of dose excreted
First 24	1.1
Second 24	2.4
Total 48	3.5—Normal less than 2

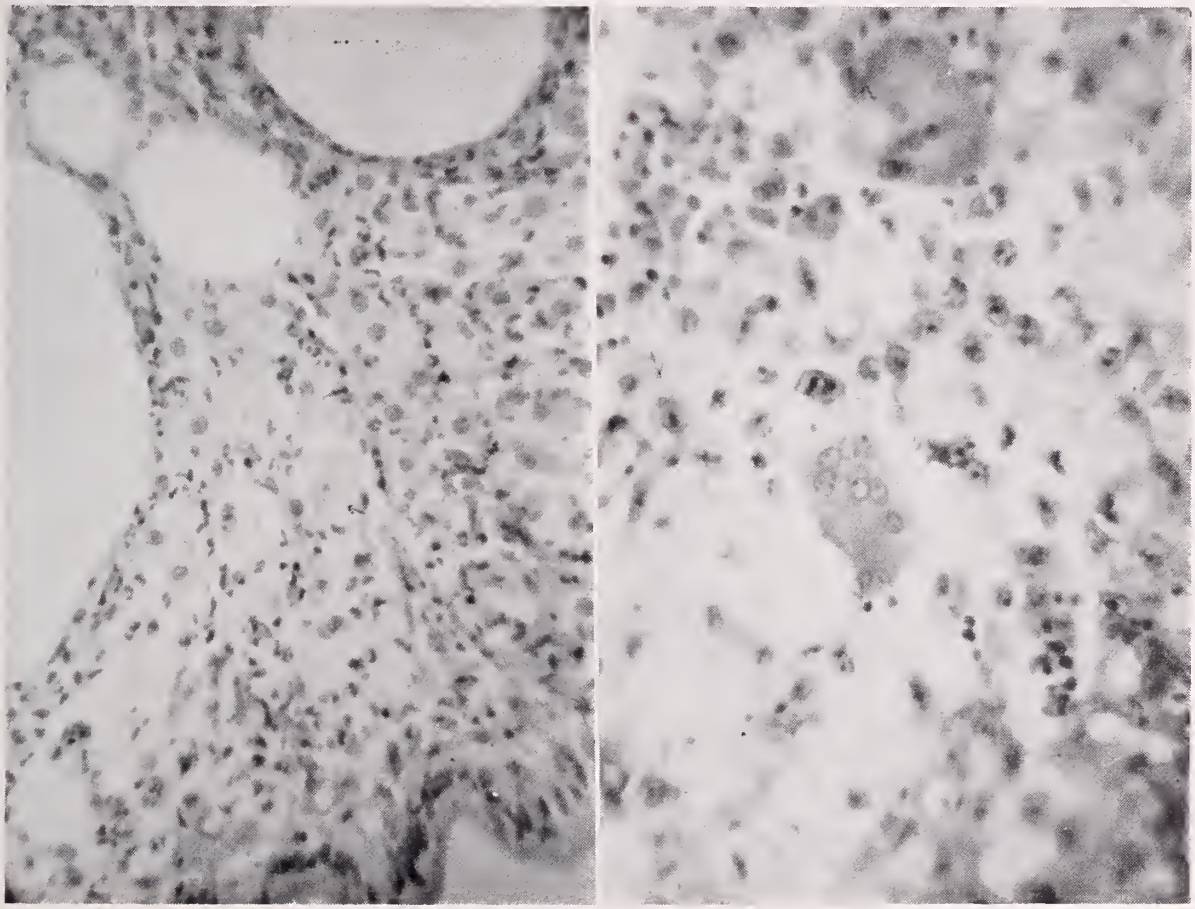
Physical examination on that admission was essentially negative except for plus one pretibial edema. During this hospitalization, there was a temperature spike to 102 F. in early evening on two separate occasions. All laboratory studies including agglutination tests for typhoid and salmonella, peripheral blood smear for malaria, antistreptolysin titer and stools for parasites were reported as negative or within normal limits. Blood, urine and stool cultures for pathogenic organisms were reported as "no growth." An upper G. I. x-ray, barium enema and intravenous pyelogram were reported as normal. The symptoms of chills, temperature elevation and arthritis all subsided during his hospital stay and he was discharged after two weeks.

For six to eight months prior to his 1964 admission, the patient had again begun to experience intermittent nocturnal chills, sweating and migratory arthritis. He continued to lose weight, with a total loss of 40 pounds since onset of symptoms in 1963. His appetite had remained good

but for the several months prior to the second admission, he was unable to eat much at one meal because of a feeling of fullness after a few mouthfuls of food. He gave a history of slight fatty food intolerance, however, denied frequent indigestion, heartburn or post-prandial belching. For two months prior to admission, he had three to four soft stools per night, described as having a normal color with no particularly foul odor, increasing to six per night during the last two to three weeks, being watery, greenish and leaving an oily film on the water. The patient denied blood in the stools or bouts of melena. Also, over a period of three to four weeks he had begun to experience intermittent upper abdominal pain radiating to the back.

On physical examination, the patient was a chronically ill 49-year-old white male showing evidence of marked weight loss, with temperature 98 F., pulse 92 and respirations 20/minute. Blood pressure was 100/65 mm. Hg. There were no masses nor visceromegaly to palpation of the abdomen; it was, however, slightly distended and tense with mild generalized tenderness. It was dull to percussion throughout. There were a few shotty nodes in the inguinal regions. There was no lymphadenopathy of the axillary or cervical regions. There was 3-plus pitting edema of the pretibial regions.

Admission blood studies in per cent were: hemoglobin 10.8 Gm., hematocrit 38 vol., total proteins 4.6 Gm., albumin 2.7 Gm., globulin 1.9 Gm., A/G ratio was 1:4. The total white blood cell count was 14,550/cu.mm. with a differential count of: neutrophils 66, bands-2, eosinophils-6, lymphocytes-22, monocytes-4. Urinalysis was normal except for a trace of albumin. Fasting blood sugar and blood urea nitrogen both were normal. Alkaline phosphatase was slightly elevated at 9.4 Bodansky units. Total cholesterols were low at 126 and the cholesterol esters 86 mg./100 ml. Latex fixation was weakly positive and the L.E. preparations negative. Prothrombin time was prolonged at 59 per cent. The five-hour glucose tolerance test showed a flat curve similar to that seen in malabsorption syndrome with the following results expressed in mg./100 ml. at noted hours: fasting-97, ½-130, 1-128, 2-126, 3-118, 4-113, 5-92. Triolene I^{131} radioactive fat study demonstrated marked impairment of fat absorption and increased fecal excretion (Table 1).



Figures 4 & 5. High magnification of the region of the lamina propria better demonstrating the larger pale, foamy histiocytes.

The patient was operated upon on the ninth hospital day, with a preoperative diagnosis of carcinoma of the pancreas because of the clinical picture of weight loss and the x-ray evidence of obstruction of the gastric outlet and widened duodenal loop (figures 1 and 2). The malabsorption syndrome suggested by the low cholesterol, flat glucose tolerance curve, and impaired Triolene I^{131} absorption was thought to be secondary to carcinoma of the pancreas.

At operation, a large mass of discrete, soft to firm retroperitoneal lymph nodes measuring 5-6 cm. in diameter was found. Similar nodes were present in the mesentery of the small bowel. The spleen was estimated to be three to four times normal size. Biopsy specimens of the jejunum and an adjacent mesenteric lymph node were obtained. The jejunum, particularly its mucosa, was thickened and edematous throughout. The microscopic picture of the biopsies was of enlarged villi with large PAS positive histiocytes packed within the lamina propria compatible with Whipple's disease (figures 3, 4 and 5).

Figure 6. Upper G.I. x-rays. The stomach was normal in size, shape and position. The duodenal loop was still noted to be enlarged, thought partly due to the high position of the stomach.

The patient's postoperative course was uneventful and his stools decreased in number to one a day, being soft in character for the six days of hospitalization before he was discharged, apparently symptom free. He was discharged in March 1964, on a low fat diet, with a body weigh of 125 pounds, having a total weight loss of 60 pounds since onset of symptoms in 1963.

Approximately two weeks following discharge, the patient again began to have three to four loose stools per day and return of the migratory arthritis. By June of the same year, his weight had dropped to 115 pounds from his normal of 185 pounds. Terramycin therapy was instituted at 250 mg. q. i. d. In less than one week the patient had an increase in sense of well being and the arthritis subsided. In two weeks from the time terramycin was started, the patient had no further diarrhea and began to gain weight. He was continued on terramycin in decreasing dosage over the next four months and the low fat diet was continued until January 1965. Improvement continued and the patient returned to work.

Because of his dramatic clinical improvement, the patient was requested to return to the hos-

Figure 7. Small bowel x-rays. The small bowel mucosal pattern appeared normal, with no evidence of a malabsorption pattern noted.

pital as an outpatient for examination and laboratory studies. When seen, his physical examination was entirely negative, and his weight was 185 pounds. Following are the laboratory studies obtained on his outpatient visit. Blood studies in per cent were: hemoglobin 14.8 Gm., hematocrit 45 vol. Total proteins 7.1 Gm., albumin 4.5 Gm., and globulin 2.6 Gm. The A/G ration was 1:7. The total white count was 8,300/cu.mm., with a normal differential count. Urinalysis was negative. Fasting blood sugar was 111 mg./100 ml. and alkaline phosphatase 2.5 Bodansky units. The cholesterol was 213 and cholesterol esters 102 mg./100 ml. Prothrombin time was normal at 100 per cent and S.G.P.T. was reported as 44 units. The five-hour glucose tolerance test was normal, with the following results expressed in mg./100 ml. at hours noted: fasting-115, ½-155, 1-151, 2-149, 3-124, 4-103, 5-106. Upper G.I. and small bowel x-ray were normal (figures 6 and 7).

Summary

Since the diagnosis of Whipple's disease is possible by peripheral node biopsy, rectal mucosal biopsy or biopsy of the small bowel mucosa via peroral tube, these patients can be saved from an unnecessary exploratory operation. It is felt that any patient presenting with migratory polyarthritis, vague abdominal pain, diarrhea and weight loss should have the benefit of the above mentioned diagnostic studies before surgery is contemplated.

The subject of the present study appears to have had a complete clinical, chemical and radiologic remission from his disease. A rectal mucosa biopsy specimen was taken for study during this period of remission and no PAS positive cells were noted. Unfortunately, no specimen of the rectal mucosa was biopsied in the hospital during the active stage of the disease; therefore, no conclusions can be drawn.

It is felt from the review of the literature and from this patient's response to terramycin that the latter should be the drug of choice in the treatment of Whipple's disease. Although the etiology is still in question the use of this relatively innocuous drug seems warranted in view of the certain fatal outcome in the untreated case.

Acknowledgement

The cooperation and assistance of the Pathology and Radiology Departments of St. Luke's Hospital are greatly appreciated.

References

1. Whipple, G. H.: A Hitherto Undescribed Disease Characterized Anatomically by Deposits of Fat and Fatty Acids in the Intestinal and Mesenteric Lymphatic Tissue, Bull. Johns Hopkins Hosp. 18:382, 1907.
2. Farman, P.: Whipple's Disease. The Clinical Aspects, Quart. J. Med. 28:163, 1959.
3. Black-Schaffer, B.: Tinctorial Demonstration of Glycoprotein in Whipple's Disease, Proc. Soc. Exper, Biol. and Med. 72:225, 1949.
4. Haubrich, William S., Watson, John H. L. & Sieracki, Joseph C.: Unique Morphologic Features of Whipple's Disease. A Study by Light and Electron Microscopy, Gastroenterol. 39:454, 1960.
5. Rowlands, David T., Jr. & Landing, Benjamin H.: Colonic Histiocytosis in Children. Report of Form Resembling That Seen in Whipple's Disease, Am. J. Path. 36:201, 1960.
6. Spain, David M. & Kliot, David A.: PAS and Sudan Positive Pulmonary Emboli in Whipple's Disease, Gastroenterol. 43:202, 1962.
7. Chears, W. C. Jr. & Ashworth, C. T.: Electron Microscopic Study of the Intestinal Mucosa in Whipple's Disease, Gastroenterol. 41:129, 1961.
8. Sieracki, J. D.: Whipple's Disease; Observation of Systemic Involvement, II. Gross and Histologic Observations, A. M. A. Arch. Path. 67:81, 1959.
9. Davis, Thomas D., Jr., McBee, James W., Borland, James L., Jr., Kurtz, Stanley M. & Ruffin, Julian M.: The Effect of Antibiotics and Steroid Therapy in Whipple's Disease, Gastroenterol. 44:112, 1963.
10. Cited by Puite and Tesluk.
11. Puite, R. H. & Tesluk, H.: Whipple's Disease, Am. J. Med. 19:383, 1955.
12. Brodoff, Murray, Hoffman, William A., DeLucas, Vincent A. & Spino, Howard M.: Intestinal Lipodystrophy (Whipple's Disease) Diagnosis by Small Intestine Biopsy Tube, JAMA 171:154, 1959.
13. Caravati, Charles M., et al.: Diagnosis of Whipple's Disease by Rectal Biopsy, Ann. Int. Med. 58:166, 1963.
14. Plummer, Kemp, Weisiger, Benjamin B., III, Caravati, Charles M.: Successful Corticotropin (ACTH) Therapy of Whipple's Disease, Arch. Int. Med. 91:784, 1953.
15. Maddocks, M. D., Ralston, M. B., & Weiden, S.: Whipple's Disease: Remission Following Nitrogen Mustard, Gastroenterol. 39:497, 1960.
16. Barua, Paul Leon & Quintanillo, Ernesto Rivas: Control With Antibiotics of Diarrhea and Malabsorption in Whipple's Disease and in Diffuse Lymphosarcoma of the Small Bowel: A connecting link between the two conditions, Gastroenterol. 46:521, 1964.

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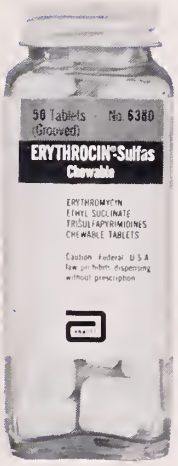

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1. Case Reports on File, Dept. Clin. Development, Abbott Laboratories.
2. Polley, R.F.L., Use of Erythromycin-Sulfas in Office Practice, Western Med., 7:177, July, 1966.

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Centennial Banquet Address

Medicine Men of the Mountains*

Perry E. Gresham, Ph. D.

WHEELING was the largest city in the new state of West Virginia in 1867 when the West Virginia State Medical Association was formed. By 1900 she could claim 38,000 to 11,000 for Huntington. A handful of capable physicians met in Wheeling to share ideas on the practice of medicine. Andrew Johnson was President of the United States. He was a Tennessee tailor born in North Carolina and about to be impeached in Washington by a group of Northerners. A century later Lyndon Johnson is President, a politician born in Texas and beset with a war in Vietnam and a riot in Detroit with no thought of impeachment, but it has occurred to some Southerners. The Johnson boys have had a rough time in the presidency. They have presided over the beginning and the end of the first century of associated medicine in West Virginia without doing very much to help along the cause in spite of wild promises and lofty claims.

There were less than 380,000 people in the nascent Mountain State in that memorable year. The Baltimore and Ohio Railroad was already in operation, but the Chesapeake and Ohio and the Norfolk and Western had not entered the State. The little city of nine or ten thousand people on the Kanawha named Charleston had not yet become the capital. In that year West Virginia University was established at the village of Morgantown.

In spite of the fact that population was sparse, roads were meager, and the mountains were formidable, medical practice was comparable with other states. The dedicated physicians made up in personal attention and common sense what they lacked in equipment, facilities and the knowledge of the science and art of medicine.

At the time of the Wheeling meeting Louis Pasteur was a professor in France with notable success but not yet much fame. He had just succeeded in the discovery of the bacteria which made possible continued advance of the wine and beer industry, which was of some importance to all mankind but crucial for France. He had not yet saved the silkworms or chased the anthrax from the flocks. Joseph Lister was Professor of Surgery at the University of Glasgow. He had not yet delivered to the world in general and to West Virginia in particular his findings with regard to the antiseptic practice of surgery. Nobody had thought to name a relatively harmless but distasteful mouthwash in his honor.

The amazing achievement of this past century is apparent only when one considers that 90 per cent of all the scientists in the history of mankind are alive today. Go back a century and you will find physicians as well as midwives bringing babies into the world without any aseptic practice with regard to clothing, air and even hands. Among others, Oliver Wendell Holmes urged scrubbing in preparation for the birth of a baby even though he did not know exactly why it was better for the mother and the infant. This distinguished *Autocrat of the Breakfast Table* had written an essay, "The Contagiousness of Puerperal Fever," in 1843 for which he was fiercely attacked by some leading obstetricians. He was unimpressed with their objections and continued to live till 1894 with the delightful philosophy that "Life is a fatal complaint, and an eminently contagious one." Over in Germany Professor Robert Koch had not yet identified the tubercle bacillus which had been causing all of the deaths in West Virginia from that dread disease called consumption. This same wise professor isolated the vibrio of cholera in the subsequent year.

Anesthetics were well known at the first session of this association. In the United States as early as mid century, there was a violent flap about who first utilized ether, while chloroform

The Author

- **Perry E. Gresham, Ph. D., President of Bethany College, Bethany, West Virginia.**

***Address presented at the Centennial Banquet held during the 100th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 24-26, 1967.**

was successfully employed in Edinburgh by Simpson in 1847. I can give personal testimony to the enormous progress from Morton in 1846 Boston and Simpson in 1847 Edinburgh, to Greeneltch in 1967 Wheeling.

A young doctor destined to become Sir Ronald Ross was in fierce pursuit of the *anopheles* mosquito which he duly apprehended in 1897 and ripped open the stomach of the fierce little beast where he found and identified the malarial parasite. Walter Reed, who is best known for his hospital where President Lyndon Johnson repaired when his physicians discovered that he had rocks here and there, collected glory by putting the finger on the *stegomyia* mosquito as the culprit involved in yellow fever and thereby made possible the completion of the Panama Canal much to the delight of Theodore Roosevelt. It now appears that politics and riots will require a repetition of the entire proceedings.

Conrad Röntgen carelessly used a key for a bookmark and discovered the new effect called x-rays which have provided important inside information to all West Virginia medicos in this century. I heard of one West Virginia patient who was so vain that he insisted on having his x-ray pictures touched up before the physician reviewed them. Medical practice has been much more rewarding and effective since the advent of radiology and more patients seem to survive. Over in France, before the WVSMA lifted a cup of cheer to welcome the 20th Century, Pierre and Marie Curie had published some of their important findings on radium with its interesting and useful implications for the practice of medicine.

In Vienna the majestic Sigmund Freud was practicing psychoanalysis and preparing mankind for a whole new branch of medicine. Much can be said for life in the last century before people were classified in terms of their early toilet training into anals who cling to things, orals who snore and talk, and genitals who do other things. Life must have been charming when the id was not impinging upon the ego with an unconscious influence which defied the super ego. In those days sex was much less complicated although probably just as popular. We are now afraid to dream!

By the time Dr. J. H. Anderson was president of this association in 1921 the golden age of German medicine was in full progress. Paul Ehrlich had discovered arsphenamine which was better known as salvarsan and 606. This was the accepted treatment for syphilis until Alexander Fleming came along with a curious preoccupation for mold on bread which he called penicillin. Before Doctor Fleming the physician's good word to the gay young blade was, "Remember, young man, an hour with Venus and the rest of your life with Mercury."

When Dr. Tom Harris moved into the presidency of this fraternity in 1945 the exciting era of antibiotics was upon us. Fleming's penicillin discovery in Paddington during 1928 was a bad day for the microbes even though they escaped full attack until World War II. Among other limitations of penicillin was the fact that it was not active against tuberculosis, but in 1944 Salman A. Waksman came through with streptomycin which has practically wiped out the great white death. Davos Platz in Switzerland, formerly a famous tuberculosis spa, is now a center for winter sports where former tuberculars die of fractures and cirrhosis of the liver. No longer do West Virginians head for the Arizona desert when tuberculosis is diagnosed. The wide variety of antibiotics now available to the learned physicians in this room have substantially reduced the death rate of free mountaineers. At long last we have the microbe on the run!

Even though immunology antedates the WVSMA with Jenner against smallpox, the greater developments were of this century. Almrouth Wright against typhoid is credited with winning the South African War for Britain with the substantial help of Lord Kitchner who commanded the troops. In World War I tetanus and diphtheria were conquered by Emil von Behring and Shibasaburo Kitasato. These victories were of enormous benefit to the medicos of this Mountain State. By the time Dr. Park McMullen was president of this association in 1955, his friend, Jonas E. Salk, had introduced a vaccine for poliomyelitis. That ancient eye crippler called measles yielded to vaccination with the beginning of this present decade. I proudly read an article by my son, Dr. Glen E. Gresham, describing the results of his immunization experiments for measles carried on at Buffalo under the auspices of the Public Health Service. In that same journal I noticed that my friend and neighbor, Dr. D. E. Greeneltch, had been elected President of the West Virginia State Medical Association. One of my friends offered the opinion that he had put more people to sleep than all the preachers in West Virginia.

In this same period the most dramatic achievements were recorded in surgery. That widely read literary physician, Alexis Carrel, was a 20th Century pioneer in vascular surgery; Harvey Cushing and his colleagues made stunning advances in neurosurgery; and the com-

bination of cystology and x-rays made possible that most unpleasant field of surgery known as urology of which I am a recent victim. God pity the old men of the last century! Thank God for Brad McCuskey!

The great name clinics such as Mayo, Crile and Halsted dominated medical history in the World War I period and have continued to influence surgical practice to our present time when facilities and highly qualified physicians have made possible advanced surgical practices in many places including our Mountain State. As this century of WVSMA history drew to a close the papers carried the first page news of artificial hearts and artificial kidneys as they had earlier carried the story of artificial lungs. Plastic tubes are making arteries expendable. This has been truly a century of medical progress. It now appears that Bob Drinkard will keep my ticker going until he sees I need a spare. The administrations of Seigle Parks and Richard Flood concluded this amazing century.

When, after 25 years of dedicated service as Dean of the Medical School at West Virginia University, Dr. Edward Van Liere witnessed the founding of the new Medical School, he was delighted to hear the University band strike up "Things go better with Coca-Cola," while the incipient medicos entered the new institution whistling "We're in the Pepsi generation." Dr. Clark Sleeth became his strong and able successor with a predilection for Dr. Pepper. The next century of West Virginia medicine will derive great benefit from this first-rate medical school with its commodious buildings, efficient laboratories and capable faculty. A visit to the Center will convince any skeptic that no stray cat has died in vain.

The achievements of many in century twenty-one will make our boasting seem childish. That master killer called cancer will lose his morbid power. Cardiac disorders will be still further reduced. Cryosurgery may find a prominent place in the correction of several disorders, one of which is the old man's nemesis. Old age itself will begin to lose its terror and my philosopher friend, who describes old age as "the period when one drags a disintegrating carcass around with him," will find the afternoon substantially more pleasant as well as longer. Those who live beyond a century will become commonplace and, as a result, Medicare will demand our "last full measure of devotion."

The paper companies who are the principal beneficiaries of Medicare may begin to subsidize medicine. A variety of technicians and nurses will take over the routine services now performed by physicians. Nursing homes will flourish like the green bay tree. Politicians will still try to buy votes by promising health, happiness and hooray to everybody.

William Lyon Phelps offered the opinion that physicians are the most learned and civilized men. When one considers the march of heroes from Hippocrates through Doctor Luke, that compassionate physician of Antioch, through such notable literary figures as Francois Rabelais, whose earthy humor helped to bring on the renaissance, and John Locke, that famous political philosopher who provided Thomas Jefferson with his basic material for the Declaration of Independence, all of whom were primarily physicians, it is apparent that Phelps was talking sense. Add to the list that most American of all philosophers and the father of psychology, William James, and the list is overpowering.

The new breed of physicians who dominate the next century of mountain medicine may bring some changes. They may be more adept at politics than were their predecessors who were indignant with government interference, but ineffective at the polls and in the lobbies. The next generation may formulate a plan that will serve the public and forestall the drift toward socialized medicine. They may encourage more capacity in medical schools to accommodate the many capable students who could become able physicians, but who are now denied the opportunity to train and serve the people who need more doctors. The new medicos may even surpass the vast achievements of the past century in research, discovery, and still more effective practice. They may find time to devote more attention to learning, literature, art, and music.

As president of West Virginia's oldest degree granting college, 23 years older than the state itself, which stands 48th in the nation for baccalaureate origins of doctors of medicine, I proudly salute the physicians of West Virginia who have brought us all through the perils of pestilence and diverse diseases to this present happy occasion at this handsome Greenbrier Hotel which is the continuing symbol of Appalachian poverty. Medicine men of the mountains, I salute you!

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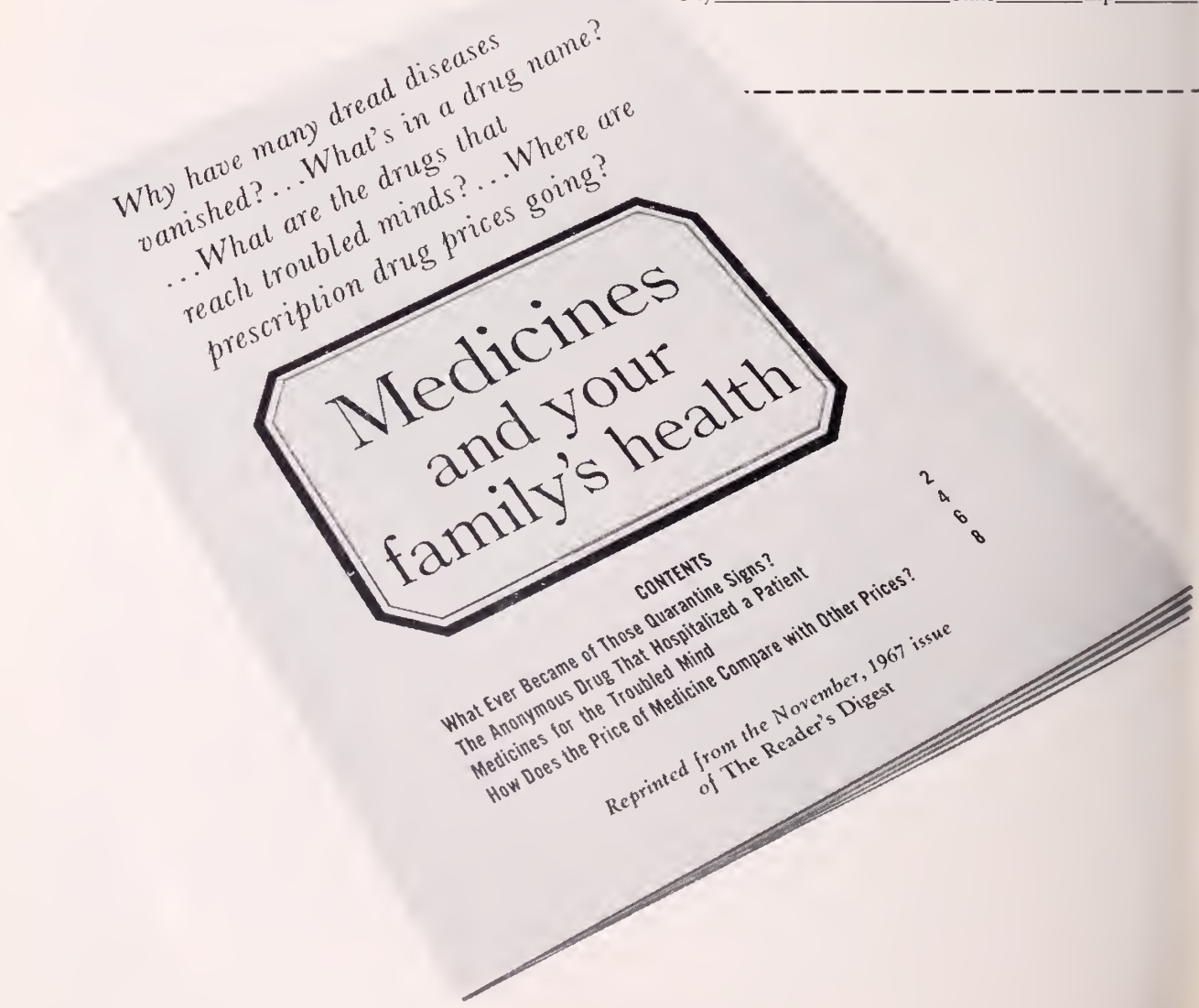

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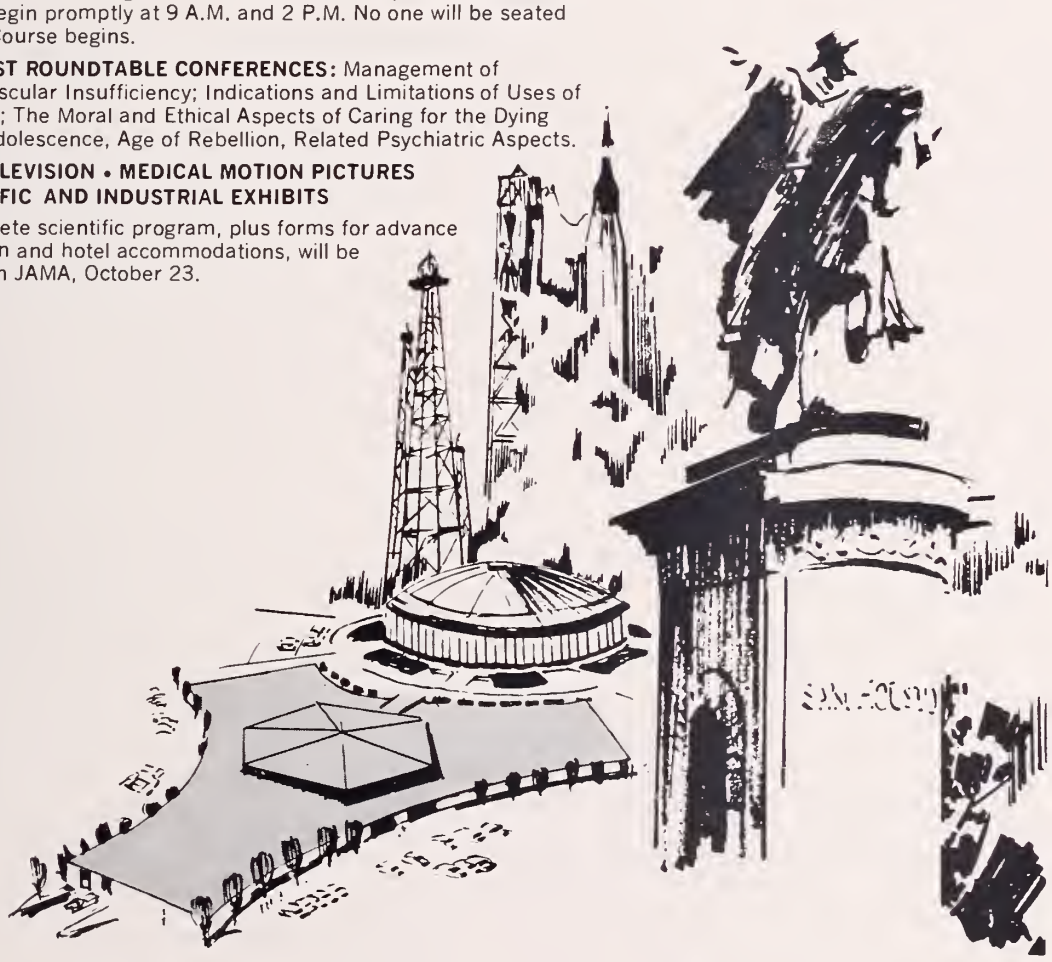

A message from . . . The President

SIMULATED DISASTER IN CLARKSBURG

One week in October, Clarksburg, West Virginia, was struck by a disaster. It was a simulated disaster as far as destruction of property and lives was concerned but it was a real disaster to our expectation of efficient and effective emergency medical care in Clarksburg and Harrison County.

In view of the two years of training and planning which preceded the test, the results brought home to me the need for physicians in medical societies to participate in such training in disaster planning. The disaster exercise was actually a test of the emergency medical care facilities in disaster plans which have been developed in the city and county. It was designed to demonstrate the emergency medical care facilities available to the city of Clarksburg and Harrison County should a national disaster strike.

For several years now the Harrison County Medical Society, St. Mary's Hospital, Union Protestant Hospital and the Clarksburg Veterans Administration Hospital have had disaster plans designed to handle such a situation. Recently, a training program of ambulance and first-aid personnel has been conducted through the State Health Department and West Virginia University. At the same time, the City of Clarksburg and Harrison County had been asked to study and prepare disaster plans for themselves involving the city police and fire departments, county sheriff's office and the West Virginia State Police. Because of this period of preparation, it was felt that such a test exercise would now be beneficial to determine the strength and weaknesses, the adequacy or inadequacy of the various disaster plans currently in existence. It was felt that such a test would reveal requirements to be met in the future should an actual disaster occur.

The disaster planned was that Clarksburg was to be hit by a tornado which would strike in rapid succession Victory High School, Notre Dame High School and Roosevelt-Wilson High School. Thirty-five to 40 simulated casualties from each school were designated and students were picked to represent the victims. Moulage tents for demonstrating various types of accidents and injuries were utilized to the fullest extent possible. A total of 19 for each high school. Other injuries were then listed on cards fastened to the accident victims who memorized a list of symptoms to relate to the medical personnel. Clarksburg Art Center then made up the students to simulate the injuries.

The tornado struck at 10 A. M. on October 10. The events that followed are those things which would naturally happen should a real disaster occur: confusion, disorganization, lack of adequate communication and improper utilization of available facilities and equipment. Also, improper availability of equipment, the lack of proper preparation of ambulance and first-aid personnel in the medical triage of victims was the most obvious fault in the disaster exercise. The first-aid performed was adequate in most instances. Lack of equipment for the splinting of fractures, however, was one of the most glaring deficiencies that appeared. Inadequate training of first-aid personnel in the recognition and treatment of shock was obvious. Transportation of the victims through the town by the use of police assistance and direction was considered to be good. The handling of the victims upon receipt by the hospitals was excellent. The majority of the victims, however, were transported to one hospital while the other two hospital emergency facilities were totally ignored until the one hospital became so overburdened they designated victims to be sent to other hospitals. This displays a total lack of communication in the dispatching of victims to the hospital which could best care for them. Many other deficiencies too numerous to mention here were noted, but the overall impression of the exercise was that more intensive medical planning for emergency medical care must be accomplished.

The job of up-dating the emergency medical care of our citizens of West Virginia is within the province of our State Committee on Medical Emergencies and Civil Defense under the chairmanship of Dr. John Mahood. It is suggested that Doctor Mahood and the members of his Committee confer with the West Virginia Department of Health and Col. Marble L. Zickefoose to develop plans for the future training of all citizens, ambulance personnel, first-aid personnel, policemen, firemen, registered nurses, licensed practical nurses, nurses aides and medical physicians in emergency medical care and disaster control so that this type of medical care can be made available to all citizens and communities in West Virginia.

Richard V. Lynch, Jr., M.D.

Richard V. Lynch, Jr., M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

WE HAVE THE MACHINERY: LET'S USE IT

When government agencies and societies wax large and certain confusions ensue, there is always some doubt as to the adequacy of the communications system. Are we getting the message down to the members and out to the public? We worry about our inability to be understood. The West Virginia State Medical Association is no exception. There arises the question of whether our communications machinery is all it should be; is it performing satisfactorily, or does it need an overhauling with perhaps a few additions?

In a recent article entitled "Communication," Dr. Hugh H. Hussey, Director of the AMA Division of Scientific Activities, defines communications thusly: "Properly used, communication is man's most valuable asset. It affords a means of getting along with fellow men. Improperly or ineptly used, it is a source of misunderstanding or even disaster."

The Founding Fathers of our Association and their successors devised ways through which the message could be carried from the top to bottom echelons. There is a House of Delegates, the members of which are duly elected by their local societies, a Council composed of a member from each of the 14 districts, a group of officers, multiple committees, and an executive staff, aided by a Journal through which medical or organizational information may be spread to all members. It would seem that these channels would be adequate for our purposes.

If communication lags or is insufficient, let's see if we can improve the functioning of some or all of our existing machinery. A full attendance at the meetings of our House of Delegates, with a precise report of the same to every society by the Delegates would be helpful. Councilors appearing before each society in their district after each Council meeting, with a critical study of matters pertaining to that meeting would add clarification to the procedure. Committees reporting more fully to the officers with reports printed in full in *The Journal* once a year, would lead to better comprehension of the work of those committees. The staff should supply Councilors with a fuller, even verbatim report of Council meetings.

The Journal can encourage more and better reporting of all our society activities at any level. The President is not restricted to the traditional monthly letter of one page; he can have two, three pages or all the space he desires to deliver his message. The AMA Delegates need not rely

on the canned copy of activities sent out by the AMA, but might add personal messages indicating their own opinions on matters presented to the House. All our known ways and means can be improved, information given more precision and the personal note used to greater advantage in appealing to reader or listener.

Hopefully, communications from the individual to the top can follow the same lines. *The Journal's* pages are always open to any member with any message relevant to medicine or medical organization.

There are additional means of improving communication if you care to pay the price. One or two field representatives of our Association visiting each county society, not once but several times a year, and reporting in detail the latest business involving our organization would assuredly unify the component societies and keep them better informed. This type of communicator does not come cheap.

With further reference to Doctor Hussey's article, it is indicated that the mere dispensing of information does not make for communication. He mentions the four elements of communication; sender, medium, receiver and receiver's reaction, and he states, "It must be agreed that the best element in the chain, the receiver's reaction, is the most important." So then we seek for that subtle, undefinable means of provoking the receiver into some reaction, any reaction that will indicate interest. Perhaps we need to invoke another cliche and start talking of setting up a "dialogue;" only then can we be sure the message is received and reaction has developed.

MEDICAL SCHOOL ENROLLMENT AND PLANNED EXPANSION

The Association of American Medical Colleges has recently distributed a datagram giving figures of medical school enrollment in the United States between the years 1956-57 and 1966-67, and also figures predicting enrollment up to the year 1971-72. In 1956-57 the first year enrollment in medical schools was 8,014; five years later (1961-62), the number was 8,298; and 10 years later (1966-67), 8,984.

Presently, responsible institutions have announced plans for the development of 15 new medical schools. It is expected that these new schools will admit 930 entering students by 1971-72. Medical schools already established have firm plans for expanding enrollment up to a total of 1,261 additional entering students by that year. In essence, if all this obtains, the total expected enrollment of entering medical students will be 10,950 in 1971. It is pointed out that this falls short by 1,050 of the 1959 recommendation of 12,000 by 1971.

The datagram fittingly calls attention to the many complex problems associated with the creation of a modern medical school. Besides the four-year medical curriculum for undergraduate students, there are other educational programs to be developed, such as those for graduate and postdoctoral students, for interns and residents, and also, courses for continuing education of physicians. Equally important to consider, is the care of patients in the teaching hospitals and clinics, and also the conduct of research both in the basic sciences and in clinical fields.

The datagram also calls attention to the approximate time it takes to develop a modern medical school. After a firm decision as to location has been made and funds secured for construction and operation of the school, it is emphasized that about two years are needed to complete the plans and about three more years to construct and equip the facility. These figures are probably somewhat optimistic for much may happen during the construction period; for example, a shortage of steel, or vexing labor strikes. Furthermore, often there is delay in obtaining and installing important permanent equipment.

Despite the many problems involved in creating a modern medical center, it is to be hoped that the number of medical graduates in this country will be substantially increased during the next few years. The United States surely should be able to train a sufficient number of physicians to take care of the health needs of its citizens, and should not have to depend upon help from other countries. It would seem that by sufficient foresight and wise planning this could be efficiently accomplished.

SAMPLES, SAMPLES EVERYWHERE

What to do with the load of sample medicine we get through the mail, the detail man and the convention has become a real problem to the physician. Some samples, especially those in the expensive bracket, such as antibiotics or steroids are given to patients; others accumulate in the office until they exceed storage space and are dumped.

Some medical societies have a collection service where valuable medicines can be distributed to the needy by clinics or various organizations. Such good fortune is nonexistent in most areas.

Some national or international medical societies will accept samples for distribution here

and abroad. For this purpose the physician must wrap, package and pay postage.

Sometimes free drugs are furnished to individual physicians to conduct and report a survey of the medical efficacy of a drug in a particular problem. Few of us have the time or clinical acumen to make such a study and none of our colleagues would read the report. All of us are dubious of that reference in a drug's bibliography termed, "Personal Communication."

Those of us who have no outlet except the dump find samples strewed over garbage areas and landfills where they can become a menace to curious children and adults.

Physicians do not use drugs solely on the recommendation of the company representative, and the possession of a few samples is not likely to control our clinical application of a medicine. So is it not proper to consider some change in the distribution of sample medicines that may be a relief to company, company representatives and physicians? Such a statement as, "samples on request only," would be helpful to all of us in the business, and the savings in postage, medicine, literature, etc, could be passed along to the consumer.

AMA MEETING IN HOUSTON

It is with great pleasure that I invite you to my home state this fall, to the AMA Clinical Convention at Houston, November 26-29. I believe you will find the convention's program particularly interesting; it offers refreshing insights into clinical problems that you will find useful in your practice or professional duties. This meeting is especially designed to help us keep up-to-date on latest medical developments. For the 21st consecutive year, the AMA has assembled an extensive, well-rounded program outlining current knowledge.

You will be impressed, I think, by the outstanding medical teachers who have accepted the invitation of the Harris County Medical Society and the AMA Council on Scientific Assembly to participate in the scientific program. The Harris County Society has done a fine job in bringing together this program.

For you, the Clinical Convention presents opportunities for refreshing your medical knowledge, for renewing associations with fellow physicians, and for catching a breather from your busy schedule. It promises to be a stimulating four days, worthy of your time.

With my colleagues, the physicians of Texas and Harris County, I cordially invite you to Houston, a dynamic, interesting city that you and your family will enjoy.

See you at the Clinical!—*Milford O. Rouse, M. D., President, American Medical Association.*

More Illness for Smokers

A large scale epidemiological study by the U. S. Public Health Service has produced new evidence that cigarette smokers suffer ill health from chronic and acute disorders to a much greater extent than nonsmokers.

The results of a 12-month study (July 1964 to June 1965) were released by the agency last May. The investigation was based on interviews in 42,000 households with about 134,000 occupants, providing a sample representative of the civilian, noninstitutionalized population of the United States.

The study disclosed that male smokers and former smokers had higher prevalence rates for a number of chronic conditions than those who had never smoked. These conditions were: all heart conditions, arteriosclerotic heart diseases, bronchitis and/or emphysema, sinusitis and peptic ulcer. Women smokers (past and present) had higher rates than nonsmokers for the last four of these categories.

Men who at the time of the interview were smoking more than two packs a day had a 70 per cent higher rate for heart conditions than those who had never smoked. Arteriosclerotic heart disease (including coronary disease) was found more than twice as frequently among males who smoked 1 to 2 packs a day than among those who had never smoked.

The strongest relationship between smoking and chronic illness was found for bronchitis and/or emphysema. Present and past smokers, male and female, had rates two to three times as high for this category as those who had not smoked at all.

For acute conditions, too, smokers had higher rates of illness than nonsmokers. The conditions considered included infective and parasitic diseases, upper respiratory conditions (including acute bronchitis), influenza, digestive system conditions and injuries. Overall, the incidence rates for these acute illnesses among persons who now smoke or once smoked cigarettes were 14 per cent higher among men and 21 per cent higher among women than for those who had never started smoking.

Smokers—past and present—had a higher number of restricted activity days, bed-days, and work-loss days than nonsmokers.—Medical Bulletin on Tobacco.

The Tentacles of Government Control

The new drug regulations were created because of certain problems which needed correcting. In an effort to be precise and encompassing, the wording was made all-inclusive. When interpretation and enforcement subsequently followed, it has been found now that not only was the total drug industry brought under complete government control, but also the whole of medicine. This means not only one phase of medicine, but the whole spirit of medicine has been made captive.—James H. Johnson, M. D., in *Annals of Allergy.*

GENERAL NEWS

20th Rural Health Conference Draws 335 Persons

The 20th Annual Rural Health Conference, sponsored by the West Virginia State Medical Association, drew an attendance of 335 persons at the State 4-H Camp at Jackson's Mill on October 5.

Dr. Martha Jane Coyner of Harrisville, Chairman of the Rural Health Committee of the State Medical Association, is shown with Mr. Jeff Hallett and Miss Judy Steel, students at Triadelphia High School and members of the 4-H Club in Ohio County. The two students were among the speakers at the 20th Annual Rural Health Conference.

The Conference is conducted each year under the auspices of the State Medical Association's Rural Health Committee in cooperation with the West Virginia Home Demonstration Council, the West Virginia Farm Bureau, the State Health Department, and the Cooperative Extension Service of West Virginia University.

Doctor Coyner Presiding Officer

The presiding officer of the Conference was Dr. Martha Jane Coyner of Harrisville, Chairman of the Rural Health Committee. The Rev. Joseph P. DeBardi, Minister of the First Methodist Church in Clarksburg, gave the invocation.

Dr. Richard V. Lynch, Jr., of Clarksburg, President of the West Virginia State Medical Association, gave the welcoming address.

Morning Program

The morning session was devoted to a panel discussion of "Cooperative Health Education Projects by the Appalachian Center and the School of Medicine, West Virginia University."

Speakers at the morning session included: Miss Mildred E. Fizer, State Chairman 4-H and Youth Development Programs, WVU Cooperative Extension Service; Miss Judy Steele and Mr. Jeff Hallett, students at Triadelphia High School and members of the 4-H Club in Ohio County; and Dr. Ernest W. Chick, Associate Professor of Medicine and Chairman of the Division of Public Health and Preventive Medicine at the WVU School of Medicine.

Afternoon Session

"New Approaches for Rural Health" was the theme of a panel discussion in the afternoon. Dr. N. H. Dyer, State Health Director, served as Moderator.

Panelists and their subjects were as follows:

Dr. Daniel Hale of Princeton, "Community Organization for Health;" Dr. I. E. Buff of Charleston, "Multiphasic Screening Program;" Mr. O. Raymond Lyons, Director of the Solid Waste Division of the State Health Department, "Solid Waste Disposal;" Mr. Donald P. Adkins, Community Organizer, Vaccination Assistance Project, State Health Department, "Measles Immunization;" and Dr. Daniel Hamaty, Director of the Division of Disease Control, State Health Department, "Home Health Services."

"Code of Fair Practices" Adopted by PMA

A comprehensive new code covering the advertising and promotion of prescription drug products has been adopted by the Pharmaceutical Manufacturers Association.

In announcing the new "Code of Fair Practices", PMA President C. Joseph Stetler termed it "a clear demonstration of the industry's good faith and determination to safeguard and improve the high standards of drug advertising and promotion."

He said that, in order to assure compliance with Federal laws, the code was submitted in advance to the Department of Justice for study. Final clearance from the Department was obtained in September.

Stetler noted that the code is an outgrowth of the industry's recognition of "the importance to the public health" of providing the medical profession with accurate information on drug products "and the need to assure that PMA members, their employees and agents present such information fairly and objectively."

The code covers advertising and promotional communications, including journal advertising, mailing pieces, films, exhibits and similar visual presentations. Also covered are written instructions and materials prepared for sales or professional representatives.

Calling for "complete and accurate" information for marketed prescription drug products, the code states that claims should "not be stronger" than substantial scientific evidence "or other responsible medical opinion warrants."

"Every effort," notes the code, "should be made to avoid ambiguity," and it calls for "a valid scientific basis" when comparing drug products.

While the code prohibits premature public communications on new drugs, it clearly states no intention to restrict "a full and proper exchange of scientific information . . . including appropriate dissemination of investigational findings in scientific or lay communications media."

The code also makes it clear that no restriction is placed on public disclosures to stockholders "and others concerning any drug product as may be required or desirable under law, rule, or regulation."

Encouraging PMA member firms to register complaints with respect to violations, the association expresses in the code its "unqualified intent" that each and every member shall follow strictly the principles set forth.

The code declares that any member firm "which clearly and persistently violates the Code may be asked to resign from the Association."

Under the formal title of the "PMA Code of Fair Practices in the Promotion of Drug Products", the code replaces an earlier set of principles which has covered ethical drug promotion practices since 1958.

PMA is a non-profit, scientific, professional and trade organization representing the manufacturers of more than 95 per cent of the nation's prescription drug products.

BS Enrollment and Benefits Reach Record

Record highs were reached during 1966 on the number of people served and medical-surgical benefits paid by Blue Shield, according to the annual report published by the National Association of Blue Shield Plans.

The Association, headquartered in Chicago, is the coordinating body of the 84 Blue Shield Plans in the United States, Canada, and Puerto Rico.

The number of persons served by Blue Shield, which had been moving toward the 60 million mark, spurted to over 71 million—more than one-third of the population.

The Blue Shield Plans paid out over $1.4 billion in benefits during 1966, up $52 million from the previous year.

John W. Castellucci, NABSP president, said that while the majority increase in those served by Blue Shield involved government programs—primarily Part B, the supplementary medical-surgical portion of Medicare—there was a net gain of almost 2 million members in regular underwritten enrollment.

"New Approaches For Rural Health" was the theme of a panel discussion at the Rural Health Conference. Participants included, front row, left to right, Mr. O. Raymond Lyons, Director of the Solid Waste Division of the State Health Department; Dr. I. E. Buff of Charleston; Dr. N. H. Dyer, State Health Director; and Mr. Donald P. Adkins, Community Organizer for the Vaccination Assistance Projects of the State Health Department. Rear: Dr. Ernest W. Chick of the WVU School of Medicine; Dr. Daniel Hale of Princeton; and Dr. Daniel Hamaty, Director of the Division of Disease Control, State Health Department.

Doctor Anderson Is Honored By D&E College

Dr. J. Howard Anderson of Welch, who served as President of the West Virginia State Medical Association in 1921, received the second annual Founders Award at Davis and Elkins College in Elkins in September.

J. H. Anderson, M. D.

Doctor Anderson, a physician for 60 years, served on the D&E Board of Trustees from 1951 until 1959, when he was named honorary trustee. The College awarded him an honorary Doctor of Science degree in 1962.

The Founders Award was established last year to honor individuals who by the donation of their time, energy and resources, have made significant contributions to the progress of the College.

Doctor Anderson, the second recipient, has been active in many civic, church and medical affairs. He has been President of the West Virginia Society for Crippled Children, as well as President of the State Medical Association, and in 1956, he was named "General Practitioner of the Year" in West Virginia.

SMA Meeting in Florida November 14-16

The 61st Annual Meeting of the Southern Medical Association will be held in Miami Beach, Florida, November 13-16.

In addition to the scientific program, there will be a number of social events.

Several conjoint societies will meet at the same time as Southern Medical. They include the American College of Chest Physicians, Southern Chapter; College of American Pathologists; Southern EEG Society; and the Southern Gynecological and Obstetrical Society.

All scientific activities, meetings and exhibits at the meeting are available to physicians who are members in good standing in their local and state medical societies. There will be no registration fee.

All members and guests at the meeting are invited to a reception honoring the President, Dr. Guy Thompson Vise, Sr. The reception will be held in the Fontaine Room of the Hotel Fontainebleau on Sunday, November 12, from 7 P.M. to 8:30 P.M.

Mr. Timothy Keefe Bowers of the West Virginia University School of Medicine will be one of several medical student representatives at the meeting.

Several West Virginia physicians will participate in the scientific program. Dr. Albert C. Esposito of Huntington will be discussant for a paper on "Hyphemia: Traumatic" which will be read before the Section on Ophthalmology by Dr. William H. Coles of New Orleans.

Doctor Esposito is Chairman of the Council of SMA.

Dr. Lawrance S. Miller of Morgantown will present a paper at the meeting of the Section on Orthopedics. His title is "The Charnley Compression Clamp in Treatment of Nonunion."

Dr. Philip M. Sprinkle of Morgantown will read a paper on "Salivary Gland Disease and Benign Lympho-Epithelial Lesion" at a meeting of the Section on Otolaryngology.

PHS Asks Physician Help In Clinical Studies

The Public Health Service is seeking the cooperation of physicians in the referral of patients who have shown evidence of unusual host resistance against the growth of cancer.

The patients will be involved in studies being conducted by the surgery branch of the National Cancer Institute at the Clinical Center of the National Institutes of Health in Bethesda, Maryland. Needed for the studies are patients who have had spontaneous regression of established tumors, prolonged survival following incomplete surgical excision of their cancers, or prolonged remissions following chemotherapy.

Physicians having patients who might be considered for the program should contact Dr. Donald L. Morton, Clinical Center, Room 10-N-22, National Institutes of Health, Bethesda, Maryland.

The National Heart Institute at the Clinical Center seeks referral of patients for a study of the most recent advances in the treatment of angina pectoris. Patients under 60 years of age with severe angina pectoris will be admitted for intensive study to evaluate the severity of the disease and to determine the effectiveness of optimal medical management.

Upon completion of their studies, the patients will be returned to the care of the referring physicians who will receive summaries of the findings.

Physicians interested in having their patients considered for admission to the Clinical Center for this study may contact Dr. Eugene Braunwald, Clinical Center, Room 7-N-220, National Institutes of Health, Bethesda, Maryland.

Doctor McGavack Named Member Of Commission on Aging

Dr. Thomas H. McGavack of Martinsburg has been appointed by Gov. Hulett C. Smith to fill an unexpired term as a member of the Commission on Aging of the State of West Virginia.

Doctor McGavack, who is Associate Chief of Staff at the Veteran's Administration Center in Martinsburg, succeeds Mr. Harry E. Flesher, who moved from the State. Doctor McGavack will serve until June 30, 1969.

Prior to moving to West Virginia in 1957, Doctor McGavack served as Professor of Clinical Medicine at New York Medical College.

American Medical Association Meeting in Houston

A diversified program with something of interest to virtually every physician will be featured at the American Medical Association's Clinical Convention, which will be held in Houston, Texas, November 26-29.

The four-day meeting will include scientific sessions on 18 major topics, four postgraduate courses, breakfast roundtable conferences, closed-circuit television and medical motion picture programs, and more than 150 scientific exhibits.

Postgraduate Courses

The postgraduate program has been expanded to four topics this year, to include "Fluid and Electrolyte Balance," "Oncology," "Cardiovascular Disease," and "Obstetrics and Gynecology." Leading medical educators will lecture at the courses, which will consist of three half-day sessions each.

Courses will be limited to 200 persons each, and they will begin at 9 A. M. and end at 2 P. M. daily.

General Scientific Program

Topics at the general scientific sessions will include: aerospace medicine, antibiotics, arthritis, cancer, cardiovascular medicine, cardiovascular surgery, dermatology, endocrinology, gastroenterology, general surgery, genitourinary treatment, geriatrics, obstetrics and gynecology, ophthalmology, otolaryngology, pediatrics, and psychiatry.

Breakfast Conferences

Breakfast Roundtable Conferences will discuss (1) indications and limitation of uses of antibiotics, (2) the moral and ethical aspects of caring for the dying patient, (3) management of cerebrovascular insufficiency, and (4) adolescence, age of rebellion; some related psychiatric aspects.

Television and Motion Pictures

An outstanding program of closed circuit color television and more than 25 medical motion pictures will be presented. Live, color television broadcasts of surgery and discussions from Houston's Hermann Hospital will be seen on a large screen in Astro Hall.

House of Delegates

The House of Delegates, the AMA's policy-making body, will hold its sessions at the Shamrock-Hilton Hotel. The West Virginia State Medical Association will be represented in the House of Delegates by Drs. C. A. Hoffman of Huntington and Frank J. Holroyd of Princeton.

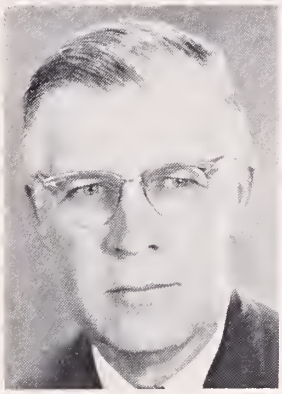
West Virginia's alternate delegates are Drs. Thomas G. Reed of Charleston and D. E. Greeneltch of Wheeling.

Athletic Injuries Conference

The 9th Annual National Conference on the Medical Aspects of Sports will be held on Sunday, November 26, at the Hotel America in conjunction with the Clinical Convention. The meeting, sponsored by the AMA Committee on the Medical Aspects of Sports, will feature morning, afternoon and evening sessions on problems faced by team physicians at all levels of athletic competition.

Dr. C. L. Wilbar, Jr., Heads Medical Organization

Dr. Charles L. Wilbar, Jr., of Morgantown, Director of the Regional Medical Program for Heart Disease, Cancer, Stroke and Related Diseases, was installed recently as President of the American College of Preventive Medicine.



Charles L. Wilbar, M. D.

Doctor Wilbar, a charter Fellow of the College, was elevated to the presidency during the group's annual meeting in Miami Beach, October 25.

A native of Pennsylvania, Doctor Wilbar succeeds Dr. Jean S. Felton, a member of the faculty of the University of California at Los Angeles.

Doctor Wilbar moved to West Virginia last summer to head the regional medical program after serving as Secretary of Health in Pennsylvania for several years. He is also Clinical Professor of Medicine, Division of Public Health and Preventive Medicine, at the West Virginia University School of Medicine.

Postgraduate Heart Course In Phoenix in 1968

A program on "Current Concepts in Cardiology" will be offered by the Institute for Cardiovascular Diseases at Good Samaritan Hospital in Phoenix, Arizona, January 10-12, 1968.

Emphasis will be placed on coronary disease, indication and management of cardiac arrhythmias, vectorcardiography and applied cardiovascular physiology.

The offering is billed as an official postgraduate course of the American College of Cardiology.

Additional information about the program may be obtained by writing to Mr. William B. Nelligan, Executive Director, American College of Cardiology, 9650 Rockville Pike, Washington, D. C. 20015.

AMA Conference on Aging

A Conference on Aging and Long-Term Care will be conducted in Baltimore, November 2-3, under the sponsorship of the Committee on Aging of the American Medical Association.

Among the topics to be explored are: adult education programs; employment counseling and placement for older persons; community service by older people; health maintenance; automated multiphasic screening; home-centered care programs; and the hospital's role in long-term care.

Dr. Irving S. Wright, President of the American College of Physicians, is among the speakers scheduled for the program.

There will be no registration fee.

Education Day at OVGH In Wheeling

Ohio Valley General Hospital's second Annual Postgraduate Medical Education Day will be held in Wheeling on Sunday, November 12.

Members of the OVGH staff will be joined by visiting lecturers in presenting papers before the medical, general surgical and obstetrics-gynecology-genitourinary sections.

Edmund B. Flink, M. D.

The sections will hold separate meetings in the morning and early afternoon. They will come together for a joint meeting at 3:30 P.M. to hear a paper on "The Hippie Revolution and LSD" by Dr. Micheal D. McGuire, Assistant Superintendent of Norristown State Hospital in Pennsylvania.

The Medical Section will discuss the problems of acid base abnormality for the practicing physician. Dr. Charles H. Hiles will moderate the discussion, and the discussant will be Dr. Edmund B. Flink of Morgantown, Chairman of the Department of Medicine at the WVU School of Medicine.

Papers will be presented by Doctor Flink and Drs. Ross O. Bell, Robert S. Robbins, Warren D. Leslie and Howard B. Sauder, all of Wheeling.

Dr. Harry T. Bahnson, Chairman of the Department of Surgery at the University of Pittsburgh School of Medicine, will be guest speaker at the General Surgical Section. He will discuss "The Surgical Treatment of Heart Disease in the Adult."

Other papers on surgery will be presented by Drs. Wilfredo Tiu, Francis M. Kivlahan and Edward C. Voss, all of Wheeling.

The Obstetrics-Gynecology and Genitourinary Section will have two guest speakers. They are Dr. Paul D. Zimskind, Professor of Urology at Jefferson Medical College of Philadelphia and Dr. Warren Lang, Associate Professor of Obstetrics and Gynecology at Jefferson.

Doctor Zimskind's topic will be "Silastic in Ureteral Obstruction," while Doctor Lang will discuss "Vaginal Infections and Their Relations to the Urinary Tract."

Local physicians presenting papers will be Drs. Bradford M. McCuskey, Donald C. Trapp and John J. Battaglino.

Cryo-Ophthalmology Meeting

The Society for Cryo-Ophthalmology will hold its 1968 session at the Statler Hilton Plaza Hotel in Miami Beach, Florida, January 14-18.

Outstanding cryosurgeons from Europe, South America and the United States will be featured.

Physicians interested in the meeting should contact Dr. John Bellows, Secretary, 30 North Michigan Avenue, Chicago, Illinois 60602.

New Association Members

Dr. K. D. Bowers, Jr., 400 Drummond Street, Morgantown (Monongalia). Doctor Bowers, a native of Beckley, was graduated from West Virginia University and received his M. D. degree in 1959 from the Jefferson Medical College of Philadelphia. He interned at the Medical College of Virginia, 1959-60, and served a residency at WVU Medical Center, 1962-66. He served with the U. S. Naval Reserve, 1960-62, and his specialty is orthopedic surgery.

* * * *

Dr. James M. Carhart, The Myers Clinic, Philippi (Barbour-Randolph-Tucker). Doctor Carhart, a native of Youngstown, Ohio, was graduated from Adelbert College, Western Reserve University in 1949. He received his M. D. degree in 1952 from Northwestern University Medical School and interned at Wesley Memorial Hospital in Chicago, 1952-53. He served a residency at University Hospital, Ohio State University, 1955-58, and served in the U. S. Army Medical Corps. His specialty is internal medicine.

* * * *

Dr. Jose A. Celis, 1200 Quarrier Street, Charleston (Kanawha). Doctor Celis, a native of Manila, Philippines, was graduated from the University of Santo Tomas and received his M. D. degree in 1955 from the University of Santo Tomas. He interned at 6208th USAF Hospital, Clark Air Force Base, Philippines, and served residencies at Santo Tomas, University Hospital, 1956-60; Hackensack Hospital, 1961-62, and N. Y. U. - Bellevue Medical Center, 1962-64. He served with the Armed Forces of the Republic of the Philippines and his specialty is urology.

* * * *

Dr. Larry D. Curnutte, 308 33rd Street, S. E., Charleston (Kanawha). Doctor Curnutte, a native of Kenova, was graduated from West Virginia University and received his M. D. degree in 1965 from the West Virginia University School of Medicine. He interned at Charleston Memorial Hospital, 1965-66, and is a member of the West Virginia Army National Guard. He is engaged in general practice.

* * * *

Dr. Hugh R. Holtrop, 58 16th Street, Wheeling (Ohio). Doctor Holtrop, a native of Ferrysburg, Michigan, was graduated from Calvin College in 1957. He received his M. D. degree in 1959 from the University of Michigan School of Medicine and interned at the University of Nebraska Hospital, 1959-60. He served residencies at the University of Nebraska Hospital, 1960-62, and Harvard University, Beth Israel Hospital, 1962-64. He served with the United States Air Force and his specialty is obstetrics and gynecology.

* * * *

Dr. G. S. Julias, The Greenbrier Clinic, White Sulphur Springs (Greenbrier). Doctor Julias, a native of Martinsburg, was graduated from the University of Virginia in 1951. He received his M. D. degree in 1962 from the Medical College of Virginia and interned at the Medical College of Virginia, 1962-63. He served a residency at the Medical College of Virginia, 1963-66, and his specialty is internal medicine.

Looking Back 10 Years...

This picture was taken ten years ago during dedicatory ceremonies for the Basic Sciences Building of the new WVU Medical Center in Morgantown on October 5, 1957. Attending the program were, from left to right, Dr. Thomas L. Harris of Parkersburg, Dr. George F. Evans of Clarksburg, and Dean E. J. Van Liere.

Albert D. Kistin Seminar In Florida

A postgraduate course in cardiology named in memory of a deceased West Virginia physician will be held at Redington Beach, Florida, November 30 through December 3 under the sponsorship of Council on Clinical Cardiology of the American Heart Association.

The course on "The Diagnosis and Management of Arrhythmias" is known as the Albert D. Kistin Memorial Seminar. Doctor Kistin, who practiced internal medicine and cardiology in Beckley, died several months ago of a heart attack.

Doctor Kistin made many outstanding contributions to the cardiovascular field, and he had planned to play an important part in this month's course in Florida.

Registration fees for the Albert D. Kistin Memorial Seminar will be $50 for Fellows and Members of the Council on Clinical Cardiology and $85 for nonmembers.

Additional information about the course may be obtained by writing to Mrs. Lorraine Kreiner, Council on Clinical Cardiology, American Heart Association, 44 East 23rd Street, New York, New York 10010.

S.S. Hope to Return to Ceylon

The S.S. HOPE will sail to Ceylon in March, 1968, marking her first return to Asia since the famous hospital ship's maiden voyage in 1960.

Ambassador Oliver Weerasinghe of Ceylon and Dr. William B. Walsh, President of Project HOPE, announced plans for the voyage.

The ship goes to Ceylon at the invitation of the government there. Educational exchange programs will be conducted in medicine, dentistry, nursing, public health, medical technology, pharmacy and other paramedical specialties.

HOPE will help to train some 500 medical auxiliaries and augment Ceylonese facilities in helping to bring care and treatment to thousands of people.

PG Course in Neurology In Cleveland

The Cleveland Clinic Educational Foundation will sponsor a postgraduate course entitled: "Pain: Neurological and Neurosurgical Aspects" in Cleveland, November 15-16.

Guest speaker will be Dr. Henry K. Beecher, Dorr Professor of Research in Anesthesia at Harvard Medical School. He will be assisted by several members of the departments of neurology, neurological surgery and anesthesiology at the Cleveland Clinic.

Registration fee will be $40 for practicing physicians; $20 for interns and residents.

Additional information may be obtained by writing to: Education Secretary, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

Seminar Planned in Parkersburg By Regional Medical Program

Dr. Jack Cole, Professor and Chairman of the Department of Surgery at the Yale University School of Medicine, will be the principal speaker at an itinerant seminar on "Cancer of the Colon, Breast and Blood," which will be held at St. Joseph's Hospital in Parkersburg on Sunday, December 3.

The one-day seminar will be sponsored by the West Virginia Regional Medical Program for Heart, Cancer, Stroke and Related Diseases, in cooperation with physicians in the Parkersburg area. The Seminar has received approval of the Committee on Medical Education and Hospitals of the West Virginia State Medical Association.

Doctor Cole will speak at the morning session which will begin at 10:00 o'clock and papers also will be presented by Dr. John B. Harley and Dr. C. H. Joseph Chang, members of the faculty of the West Virginia University School of Medicine. A physician from the University will remain as a consultant, visiting various hospitals in the area for several days.

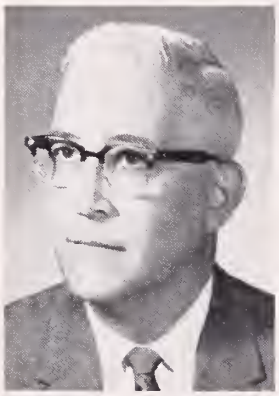
Following the address by Doctor Cole at the morning session, a film on "Diagnosis and Management of Cancer of the Colon and Rectum" will be shown. The afternoon session will feature a panel discussion by the morning participants, a pathologist (Dr. Charles W. Thacker of Camden-Clark Hospital), two physicians from the local area, a psychiatrist and a nurse.

Invitations to the Seminar are being extended to all medical and osteopathic physicians in the following nine counties: Jackson, Wood, Calhoun, Tyler, Doddridge, Gilmer, Wirt, Pleasants and Ritchie. Interested physicians outside the nine-county area also are cordially invited to attend.

A $5.00 registration fee will be charged for the Seminar, in addition to the cost of lunch. Checks covering the registration fee only should be made out to West Virginia University, and mailed to the West Virginia Regional Medical Program, Room 1367, WVU Medical Center, Morgantown, West Virginia 26505.

Dr. Lynch Heads TB Assn. For Another Year

Dr. Richard V. Lynch, Jr., of Clarksburg, President of the West Virginia State Medical Association, has been re-elected President of the West Virginia Tuberculosis and Health Association.



Richard V. Lynch, Jr., M. D.

Doctor Lynch was named to another term during the TB and Health Association's annual meeting in Princeton in September. Other officers for the coming year include: Mr. E. R. Phelps of Bluefield, Vice President; Mrs. Spencer Creel of Parkersburg, Secretary; and Mr. Winton R. Houck of Charleston, Treasurer.

Two related organizations, the West Virginia Conference of Tuberculosis Workers. and the West Virginia Thoracic Society, also elected officers. Mrs. James Owen of Princeton was named President of the Conference of Tuberculosis Workers.

Serving with Mrs. Owen will be Mrs. Grace Wolfe of Charleston, Vice President, and Mrs. Lillian McGuire of Ronceverte, Secretary-Treasurer.

The Thoracic Society, the Association's professional medical branch, elected Dr. G. R. Maxwell of Morgantown as President. Dr. Charles E. Andrews, Professor of Medicine at the West Virginia University School of Medicine, was named Vice President, and Dr. Karl Myers of Philippi was chosen Secretary-Treasurer.

Dr. Robert Anderson of New York, President and Medical Director of the American Thoracic Society, was speaker at the Annual Banquet.

He said it appears that complete control of tuberculosis is two generations in the future.

"While some progress in control of this disease has been shown since the advent of the miracle drugs, complete control is still years away," he added.

Doctor Anderson said the future treatment of tuberculosis will take place more and more in the home rather than in the hospital.

Federal Government Steps Ups Anti-Smoking Drive

The federal government has stepped up its campaign against cigarette smoking with the issuance of a new report and the appointment of a Lung Cancer Task Force.

A second Public Health Service report on the subject summarizes three and one-half years of research and study into the health dangers of smoking. The Department of Health, Education and Welfare said the report confirms and strengthens the conclusions of a 1964 report. The second report provides new technical data on the relationship of smoking to cardiovascular, chronic bronchopulmonary disease, cancer and other conditions.

—Cigarette smokers have substantially higher rates of death and disability than their nonsmoking counterparts in the population. This means that cigarette smokers tend to die at earlier ages and experience more days of disability than comparable nonsmokers.

—A substantial portion of earlier deaths and excess disability would not have occured if those affected had never smoked.

—If it were not for cigarette smoking, practically none of the earlier deaths from lung cancer would have occurred; nor a substantial portion of the earlier deaths from chronic bronchopulmonary diseases (commonly diagnosed as chronic bronchitis or pulmonary emphysema or both); nor a portion of the earlier deaths of cardiovascular origin. Excess disability from chronic pulmonary and cardiovascular diseases would also be less.

—Cessation or appreciable reduction of cigarette smoking could delay or avert a substantial portion of deaths which occur from lung cancer, a substantial portion of the earlier deaths and excess disability from chronic bronchopulmonary diseases, and a portion of the earlier deaths and excess disability of cardiovascular origin.

Dr. Kenneth M. Endicott, director of the National Cancer Institute, is chairman of the Lung Cancer Task Force made up of 10 physicians and scientists.

Dr. Endicott said that the group will concentrate on research for the development of a less hazardous cigarette, prevention of occupational cancer due to exposure of workers to cancer-causing substances in their working environment, and improvement of the present low lung cancer cure rate of five per cent.

American College of Surgeons Admits 10 State Men

Ten West Virginia physicians were admitted to the American College of Surgeons during special ceremonies held in conjunction with the ACS meeting in Chicago on October 5.

New Fellows of the ACS include: Drs. Philip M. Dreatherage, Berkeley Springs; Meredith Rohani, Charlton Heights, Fayette County; John W. Kramer, Fairmont; D. Ewell Hendricks, Martinsburg; James E. Bowers, Princeton; and Joseph R. Lancaster, Walter H. Moran, Jr., Philip Sprinkle, Thomas J. Tarnay, and James H. Wiley, all of Morgantown.

Three West Virginia surgeons presented papers at the meeting.

Doctor Moran, Associate Professor of Surgery at the WVU School of Medicine, and Dr. Jay Hoppenstein, Resident in Surgery at the Medical Center, presented a paper entitled "Antidiuretic Hormone (ADH) Blood Levels in Infants from Birth to Three Months of Age."

Dr. Bernard Zimmermann, Professor and Chairman of the Department of Surgery at the Medical Center, read a paper entitled "Acute Complications of Biliary Surgery" at the ACS Postgraduate Course on Biliary Surgery.

Suicide Among Leading Causes Of Death Annually

Physicians, as well as members of other professions whose training has prepared them to recognize suicidal signals and respond appropriately to them, must become more alert to suicide danger signs if the rise of suicide is to be averted. This was the opinion of State Health Director N. H. Dyer in a recent issue of the "State of the State's Health."

"Professionals working to develop effective methods of preventing suicide have accepted the assumption that the potential suicide will ask for help and that help can be given," the health official said. He pointed to studies which showed that 75 per cent of suicides have seen a doctor within six months of death.

Doctor Dyer reported that every year in the United States 20,000 persons kill themselves. "The actual number is far greater," he said, "for many times the real cause of death is not detected or is deliberately misstated."

Reviewing statistics, Doctor Dyer cited suicide 12th in West Virginia this fiscal year with a total of 178 deaths. He stated that suicide has ranked among the first 10 causes of adult deaths in the United States for most of the past half century and was listed as the 10th leading cause of death in our state last year.

Doctor Dyer quoted statistics assembled by the National Center for Health Statistics. Suicide is represented proportionately among all levels of society. It is the third cause of death in the 15-19 age group nationally, exceeded only by accidents and cancer. Among college students, suicide is the second cause of death, topped only by accidents.

The suicide rate per 100,000 persons for the total population of the United States is 10.5. The rate of male suicides is higher than that for females and suicides are more frequent in the white population. Geographically, national statistics show the rate of suicides is highest in the western mountain region and along the Pacific Coast. The rate of suicides in nonmetropolitan areas is slightly higher than the national metropolitan rate.

The marital status of an individual has a definite relationship to potential suicide risk. National statistics show that for single persons, the rate is 20.9; for married persons, 11.9; for the widowed, the rate is 23.8, and for divorced persons, the rate is 39.9, including the extremely high rate of 69.4 for divorced males, as contrasted to a rate of 18.4 for divorced females.

The health director emphasized that often a suicide might have been prevented if certain clues had been recognized. Suicide threats and attempts must be taken seriously. According to statistics, of any 10 people who kill themselves, eight have given warnings of their suicidal intentions. A voiced concern that some friend is contemplating suicide may reveal that the speaker himself is thinking of suicide.

Making a will, discussing insurance policies, getting affairs in order, and similar activities are warning signals of possible suicide if these actions are accompanied by suicidal talk or action and general unhappiness.

Additional clues may include chronic sleeplessness, loss of weight and appetite, withdrawal from social contacts, loss of sexual drive, loss of interest in hobbies, excessive worry over health, or any changes in behavior that make a person seem quite "different" from his usual self.

"Such symptoms should be reported to the family physician," Doctor Dyer said. "When the symptoms have been confirmed by the physician, and when professional treatment has been prescribed, the life of the person is in the hands of the people around him."

"Individuals who wish to kill themselves are suicidal only for a limited period of time," Doctor Dyer pointed out. "If they are saved from self-destruction, they can continue to lead useful lives."

Viet Nam Volunteer Program Attracts 293 Physicians

The Volunteer Physicians for Viet Nam Program sent 293 doctors to that war-torn country to aid the civilian population during the first two years of the program.

The figures cover the period from July 1, 1965, to June 30, 1967, and do not include those physicians who have gone abroad since July 1. Current programming calls for the continuing recruitment of 32 volunteers every 60 days.

According to Dr. Charles H. Moseley, the American Medical Association's Director for the Project, the requirement may increase to 50 every 60 days. Included in the present bi-monthly complement are 16 general practitioners and medical specialists (internists and pediatricians) and 16 surgeons, general surgeons, orthopedic surgeons and ophthalmologists).

Physicians sent to South Viet Nam under the program serve a 60-day tour of duty at one of a score of provincial civilian hospitals. The volunteer receives only his transportation and an expense allowance of 10 dollars a day.

In a letter to state medical association presidents, Dr. Milford O. Rouse, President of the American Medical Association, heartily endorsed the project and said more applications, especially from general and orthopedic surgeons, general practitioners and internists, are needed.

During the two-year period ended last June 30, California, with 39, supplied the highest number of physicians for the program, followed by New York with 25 and Texas with 19.

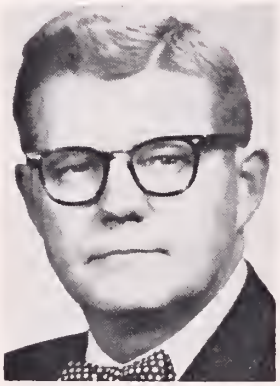
West Virginia has been represented by two physicians, Drs. Richard A. Currie of Morgantown and Robert W. Neilson, Jr., of Bluefield.

"This medical asistance program has done much to improve the image of American medicine and the American physician," Doctor Rouse wrote the state medical association presidents.

Physicians wishing to sign up for a 60-day tour should contact Dr. Charles H. Moseley, Volunteer Physicians for Viet Nam, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Heart Association Re-Elects Doctor Warden

Dr. Herbert E. Warden of Morgantown, Professor of Surgery at the West Virginia University School of Medicine, has been re-elected President of the West Virginia Heart Association.



Herbert E. Warden, M. D.

Doctor Warden was named at the Association's Annual Meeting, which was held at Oglebay Park in Wheeling, September 29-30. Almost 300 physicians and lay people attended the sessions.

Re-elected Chairman of the Board was P. J. Corbitt, D. D. S., of Parkersburg. Mr. Jack L. Lewis of Bluefield was elected Vice Chairman.

Named President Elect was Dr. Robert J. Marshall of Morgantown, Professor of Medicine and Chief of Cardiology at the WVU Medical Center.

Dr. Richard V. Lynch, Jr., of Clarksburg, President of the West Virginia State Medical Association, was elected Vice President. Mrs. Oneita Mascioli of Morgantown was named Secretary, and Miss Mary Helen Thompson of Charleston was re-elected to the post of Treasurer.

Thirty persons—15 physicians and 15 laymen—were elected to the Board of Directors.

Six members of the West Virginia Heart Association were official representatives of the group at the American Heart Association sessions in San Francisco, October 20-24. They were Doctors Warden, Marshall and Corbitt; Dr. Upshur Higginbotham of Bluefield; Dr. Michael Wilson of Morgantown; and Mr. William Diefenbach of Wheeling.

PHS Publishes New Book On Drug Practices

Native drug practices, from prehistoric tribal rites to the contemporary psychedelic scene, are given historial perspective in a new book, "Ethnopharmacologic Search for Psychoactive Drugs," just issued by the National Institute of Mental Health, U. S. Public Health Service.

The 450-page publication contains the proceedings of a symposium held earlier this year in San Francisco under the sponsorship of the Psychopharmacology Research Branch of the NIMH. Speakers from more than 10 nations met for the first time to exchange information and stimulate research in a field that professionals feel has been relatively neglected.

Although the use of plants or their extracts for medicinal and religious purposes is practically as old as the human race, this symposium was the first attempt to bring together international experts and to consolidate all presently available information. Participants were invited from a wide variety of scientific disciplines to discuss current progress and problems in the area of historical drug research.

One of the problems of research in this field is the difficulty encountered in tracing native drug practices back through history. As the science of drug chemistry has become more complex, the primary sources of these drugs have too often been lost in obscurity. At the same time, the intrusions of civilization have progressively destroyed many of the original botanical sources. Thus, according to Dr. Daniel H. Efron of the Psychopharmacology Research Branch, who edited the book, "time is running out if we want to save this information, and perhaps use for medicinal purposes some of the unknown compounds contained in some of these plants."

Included in the book are chapters devoted to kava, snuffs, mushrooms and modern hallucinogenic agents as they have been used worldwide through the centuries.

Piper methysticum, or kava, is a beverage taken by South Sea Islanders as a social and ceremonial drink and plays an important role in their tribal folklore. Farther north, Venezuelan tribesmen still follow the same snuff habits that were first reported by Amerigo Vespucci in 1504. During his initial voyage to South America, Vespucci described the natives as "having cheeks bulging with a green herb which they chewed like cattle." Completing the global circuit, scientists also gave an extensive account of the Fly Agaric mushroom, used by several Russian tribes as an hallucinogenic agent.

In an address on "Perspectives on the Use and Abuse of Psychedelic Drugs," Dr. Daniel X. Freedman of the University of Chicago explained the interest of research scientists in finding links between native drug practices and the current use of hallucinogenic drugs.

"History does indeed record our unceasing urge to transcend limits and escape dreary reality or anxiety with the aid of magic, drugs, drama, festival rites, and through dreams," Doctor Freedman said. "Even though we could doubt that drugs produce pleasure without the risk of harm, and wonder if man is built to sustain and to manage more than a brief chemically induced glimpse of paradise, we must still examine the data of ethnology, pop culture and clinical data for real evidence," he says.

"For the future," Doctor Efron commented, "we must gather more information about these compounds used in native medicine and culture, and also discover the mechanisms of action. Such compounds are not only drugs, but are potential tools that may help us elucidate information as to how the central nervous system works."

Copies of the book, Public Health Service Publication No. 1645, are available at $4, Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

ACP Schedule of Courses For 1967-68

The American College of Physicians' postgraduate course schedule for the remainder of 1967-68 is as follows:

Nov. 15-18—"Neurologic Aspects of Internal Medicine," Durham, North Carolina.

Nov. 27-30—"Medical Genetics," Ann Arbor, Michigan.

Dec. 4-8—"Radio-Isotopes and Nuclear Radiations in Medicine," Berkeley, California.

Dec. 11-15—"Advances in Medical Oncology," Houston, Texas.

Jan. 15-19—"Neurology and the Internist," Miami Beach.

Feb. 5-9—"Psychiatry and the Internist," Los Angeles.

Feb. 19-23—"Intensive Care Units," Cincinnati.

Feb. 28-Mar. 2—"Hypertensive Cardiovascular Diseases: Mechanisms and Treatment," Montreal.

Mar. 14-16—"The Clinical Selection of Patients for Cardiac Surgery," Rochester, Minnesota.

Mar. 18-22—"Psychiatry and the Internist," Albany, New York.

Mar. 27-30—"Current Concepts in Physiology of Respiration, Circulation and Electrolyte Metabolism," Boston.

Apr. 22-26—"Clinical Endocrinology — Recent Advances in Diagnosis and Treatment," Rochester, Minnesota.

May 12-15—"Frontiers in Gastroenterology," Philadelphia.

May 20-24—"The Prevention and Early Detection of Disease in Clinical Practice," Philadelphia.

May 27-31—"Auscultation of the Heart," Philadelphia.

June 10-14—"Basic Principles in Internal Medicine—1968," Iowa City, Iowa.

June 17-19—"Intensive Care Units," Denver.

June 19-21—"Infectious Diseases—Mechanisms and Manifestations," Baltimore.

Tuition fees include $60 for each course for ACP members and $100 for nonmembers.

Additional information may be obtained by contacting Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania.

AMA Releases Annual Report On Medical Licensure

Another 8,596 licensed physicians were added to the U. S. medical profession in 1966, according to a report by the American Medical Association's Council on Medical Education.

As of December 31, 1966, there were 300,376 physicians in the U. S. The total includes 243,391 licensed physicians, a net gain after deaths, retirements, etc., of 3,768 licensed physicians from the same date a year earlier.

The figures do not mean that only the 243,391 licensed physicians were qualified to take care of patients. Thousands of physicians, working under various medical, educational, and military-service permits—including most interns and some residents, as well as military and other government-service doctors—contribute to patient care. AMA records indicate that as of December 31, 1966, approximately 267,000 physicians were involved in patient care.

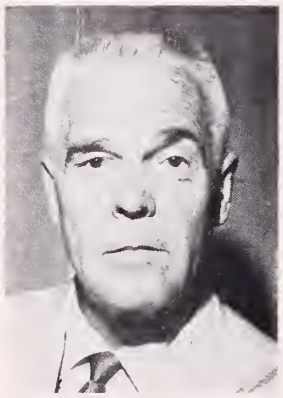
There were 626 fewer physicians receiving their first license in 1966 than in 1965. There were, however, 685 more than the total newly licensed in 1964.

New York state again had the greatest number of new physicians receiving their first license (1,045), and California was second (855). However, California's total was down 190 from 1965, and New York's was down 147. This was mainly due to a decrease in foreign-trained physicians receiving their first U. S. license, the report said.

Dr. Richard V. Lynch, Jr., of Clarksburg, President of the West Virginia State Medical Association, (center in left picture) paid his official visit to the Central West Virginia Medical Society at a meeting held at West Virginia Wesleyan College in Buckhannon on October 4. Shown with Doctor Lynch are Dr. Stanley H. Martin, (left) President of the College, and Dr. George T. Hoylman of Gassaway, retiring President of the Society. In the right photo, the newly elected President, Dr. Robert L. Chamberlain (left) confers with the Secretary-Treasurer, Dr. Joseph B. Reed. Looking on is Dr. Rigoberto Ramirez. All three physicians practice in Buckhannon.

State Diabetes Association Elects Dr. Pickens

Dr. J. Keith Pickens of Clarksburg was elected President of the West Virginia Diabetes Association during the group's annual meeting at Oglebay Park in Wheeling on October 1.



J. Keith Pickens, M. D.

Doctor Pickens succeeds Dr. Lyle D. Vincent of Parkersburg.

Other new officers for the coming year include:

Dr. Delmer J. Brown of Parkersburg, President Elect; Dr. Edmund B. Flink of Morgantown, Vice President; Dr. Margaret Albrink of Morgantown, Secretary-Treasurer; and Mrs. Alan J. Arthur of Charleston, Executive Secretary.

Symposium in Charleston Planned By WVU and Thoracic Society

A symposium on "Chronic Obstructive Disease of the Lung," co-sponsored by the West Virginia University School of Medicine and the West Virginia Thoracic Society, will be held at Holiday Inn I in Charleston on Sunday, December 10.

Dr. Ralph H. Nestmann of Charleston will serve as moderator for the one-day symposium. Registration will begin at 9:00 A. M. and the following members of the faculty of the West Virginia University School of Medicine will present papers at the morning session:

"Definition, Etiology and Pathology" — William Keith C. Morgan, M. D., Associate Professor of Medicine.

"Diagnosis and Natural History"—N. Leroy Lapp, M. D., Instructor in Medicine.

"Relationship to Asthma" — Benjamin M. Stout, M. D.. Assistant Professor of Medicine.

"Management of Acute Respiratory Insufficiency" —David Russakoff, M. D., Instructor in Medicine.

The afternoon session will feature a paper on "Management" by Dr. Charles E. Andrews, Professor of Medicine. Following the talk by Doctor Andrews, there will be case presentations and a panel discussion with a question and answer period.

Symposium participants may also make reservations for December 9 to attend the West Virginia University - University of Florida basketball game or the Kanawha Players' production of "Raisin in the Sun." In order to secure basketball tickets, reservations must be returned by November 10.

Reservation forms should be returned to Thomas A. Deveny, Jr., West Virginia Tuberculosis and Health Association, P. O. Box 341, Charleston, W. Va. 25322.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1967

Nov. 9-11—Sou. Thoracic Surg. Assn., Dallas.
Nov. 13-16—Southern Medical, Miami Beach.
Nov. 16-19—Nat. Soc. for Crippled Children & Adults, Los Angeles.
Nov. 25-26—Am. Col. of Chest Phys., Houston, Texas.
Nov. 26-29—AMA Clinical Meeting, Houston, Texas.
Nov. 29-Dec. 3—Am. Med. Women's Assn., Atlanta.

Dec. 2-7—Am. Acad. of Dermatology, Chicago.
Dec. 4-6—Sou. Surgical Assn., Hot Springs, Va.

1968

Jan. 17-18—Am. Rheumatism Assn., Baltimore.
Jan. 20-25—Am. Acad. of Orthopaedic Surgeons, Chicago.
Jan. 29-31—Soc. of Thoracic Sur., New Orleans.

Feb. 3-7—Am. Acad. of Allergy, Boston.
Feb. 6-10—Am. Col. of Radiology, Chicago.
Feb. 23-24—ACP Regional, Cincinnati.
Feb. 28-March 3—Am. Col. of Cardiology, San Francisco.

March 18-20—Am. Acad. of Ped., Atlanta.
March 24-29—Am. Col. of Allergists, Denver.
March 29-30—AMA Nat. Conf. on Rural Health, Seattle.
March 29-31—Am. Soc. of Int. Med., Boston.

April 1-5—ACP, Boston.
April 7-11—Am. Assn. of Neur. Surg., Chicago.
April 16-19—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 17-19—Maryland Medical, Baltimore.
April 22-24—Am. Assn. for Thoracic Surg., Pittsburgh.
April 22-25—Am. Col. of Ob. & Gyn., Chicago.
April 22-27—Am. Acad. of Neurology, Chicago.
April 25-26—Am. Hosp. Assn., Hollywood, Fla.

May 1-2—Am. Ped. Soc., Atlantic City.
May 7-8—Assn. of Am. Phys., Atlantic City.
May 12-17—Am. Psy. Assn., Boston.
May 13-16—Am. Urological Assn., Miami Beach.
May 14-17—Ohio Medical, Cincinnati.
May 19-22—Nat. TB Assn., Houston.
May 23-25—Am. Gyn. Soc., Hot Springs, Va.

June 14-15—Am. Rheumatism Assn., Seattle.
June 15—Acad. of TB Phys., San Francisco.
June 15-16—Am. Diabetes Assn., San Francisco.
June 16-20—Am. Col. of Chest Phys., San Francisco.
June 16-20—Am. Col. of Preventive Med., San Francisco.
June 16-20—AMA, San Francisco.
June 17-19—Am. Neurological Assn., Washington.
June 20-22—Am. Med. Women's Assn., San Francisco.
June 26-27—Am. Geriatrics Soc., New Orleans.

Aug. 12-15—Am. Hosp. Assn., New York.
Aug. 22-24—101st Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.

Sept. 5-7—Am. Assn. of Ob. & Gyn., Hot Springs, Va.
Sept. 13-15—W. Va. Heart Assn., Charleston.
Sept. 13-22—AAGP, Las Vegas.
Sept. 15-20—Int. Cong. on Alcohol & Alcoholism, Washington.
Sept. 24-26—Ky. Medical, Louisville.

Oct. 7-11—Pa. Medical, Pittsburgh.
Oct. 13-16—Va. Medical, Roanoke.
Oct. 14-18—ACS, Atlantic City.
Oct. 19-24—Am. Acad. of Ped., Chicago.
Oct. 27-Nov. 1—Am. Col. of Oph. & Otol., Chicago.

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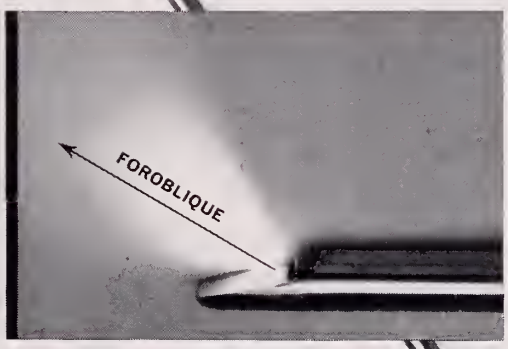

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WVU Medical Center
—News—

DR. Charles E. Andrews, Professor of Medicine in the School of Medicine, has been named Acting Director of the Medical Center.

The appointment, effective October 1, was announced in September by Dr. James G. Harlow, President of WVU. Doctor Andrews succeeds Dr. Edward G. Stuart, who died last June 22.

Charles E. Andrews, M. D.

Edmund B. Flink, M. D.

A native of Oklahoma, Doctor Andrews attended New York University and received his M. D. degree in 1949 from the Boston University School of Medicine. He is a specialist in pulmonary diseases and has been on the School of Medicine faculty since 1960.

Doctor Andrews is a member of the Monongalia County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Dr. Flink Named to Examining Board

Dr. Edmund B. Flink, Professor and Chairman of the Department of Medicine, has been appointed to the American Board of Internal Medicine. The Board examines candidates for certification in internal medicine.

Doctor Flink also has been appointed a member of the Review Committee of the Bureau of Health Manpower of the Department of Health, Education and Welfare. The Committee has responsibility for reviewing requests for new construction of medical school facilities.

Scholarship Winner

James H. Ashworth, a first-year medical student from Buckhannon, has been named a New York Life Insurance Company Medical Scholar at WVU. He is the second recipient of the award, which was begun last year.

- **Compiled from moterial furnished by the Medical Center News and Informotion Services, Morgantown, West Virginia.**

The scholarship covers tuition, books, housing, board and equipment for four years of study. It is subject to annual renewal based on satisfactory performance of the recipient.

Ashworth is the son of Mrs. Hazel R. Ashworth of Buckhannon and the late Dr. A. L. Ashworth. He is a graduate of Buckhannon-Upshur High School, and he completed his pre-medical education at WVU.

Other Scholarships

Twenty-seven other scholarships for the current year were awarded recently to School of Medicine students.

For the third straight year, the $1,000 Pfizer Laboratories Scholarship was awarded to Fred A. Brindle, a fourth-year student from Martinsburg. Paul V. Akers, third-year student from Huntington, and Linda Ann Long, a second-year student from Morgantown, were named recipients of the Joseph Collins Foundation Award.

Twenty-four students received Board of Governors' Graduate Scholarships, which cover tuition. Recipients are:

First-year students—Stephen J. Feaster, Shinnston; Richard Gnegy, Oakland, Maryland; Evelyn A. Hearl, Hemphill; Timothy J. Looney, Charleston; Charles F. Marsh, San Francisco, California; and Nolan C. Parsons, Jr., Belmont.

Second year—James C. Bosley, New Creek; Gary J. Marcus, Bethlehem, Pennsylvania; Frederick S. Raines, Charleston; Sandra S. Woolfitt, Charleston; David P. Lee, Nitro; and Linda Ann Long, Morgantown.

Third-year—James R. Castle, St. Albans; Robert J. Fagioletti, Grindstone, Pennsylvania; Robert B. Gainer III, Clarksburg; Michael J. McGinnis, Pittsburgh; Roger F. Nichols, St. Albans; and Richard J. O'Brien, Jr., Wheeling.

Fourth-year—Timothy K. Bowers, Martinsburg; James W. Campbell, Weirton; W. Albert Dow, Clairton, Pennsylvania; Frederick G. Newton, Hinton; Marion B. Tallent, Jr., Martinsburg; and Ronald L. Wilkinson, Charleston.

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The Month in Washington

• **From the Washington Office of the American Medical Association.**

THE American Medical Association urged that Congress precisely define "public health services" to prevent the so-called "Partnership in Health" legislation being used as authority for unlimited expansion of government medicine.

In a letter to Chairman Lister Hill (D.-Ala.) of the Senate Committee on Labor and Public Welfare, Dr. F. J. L. Blasingame, executive vice president of the AMA, said:

"We are especially concerned with a lack of definition with respect to comprehensive public health services. Neither 'comprehensive' nor 'public health services' is defined in the law or the bill. While we recognize there is supportable advantage in removing strict categorization of grant funds, we are concerned that the categorical identification having been removed, there will no longer be any limitation on the health care which may be provided. Indeed, from testimony on this legislation by government officials, it would appear that our concern is justified. Is the intent that the Congress is authorizing a program of *individual treatment* for *unidentified patients* for *unspecified conditions* for *unlimited services?* It is clear that the lack of definition of 'public health services' is, in effect, an invitation from Congress to unlimited expansion of 'public health' beyond its traditional role in the community.

"The AMA has supported, and continues to support the furnishing of public health services. We have also supported flexibility of operation within the state and local health departments as an effective tool for community health. We feel, however, that the distinction between the public and private health sectors should be delineated . . . in more positive terms than the mere prohibition against interference with the existing patterns of private professional practice . . . Accordingly, the Association finds itself unable to support this portion of the legislation providing for an undefined program of comprehensive public health services."

The AMA also opposed a provision for federal licensure of clinical laboratories on the ground that licensing of such facilities traditionally has been a state matter.

"We believe that federal licensure of these facilities would establish an undesirable precedent," Doctor Blasingame said.

Generic vs. Brand Name Drugs

The controversy over generic vs. brand name drugs was aired at hearings of the Senate Finance Committee and the Senate Small Monopoly Subcommittee.

Chairman Russell B. Long (D., La.) of the Finance Committee planned to offer an amendment to the Social Security bill, which includes medicare and medicaid changes, to put the emphasis on generic drugs in government medical programs. The monopoly subcommittee, headed by Sen. Gaylord Nelson (D., Wis.), was investigating drug pricing policies with the same objective as Long's proposal.

Long's proposal included the creation of a federal panel to select the highest quality but lowest cost prescription drugs for which patients would be reimbursed under government medical programs.

Both the Food and Drug Administration and the drug industry opposed establishment of such a committee and national formulary of drugs.

FDA Commissioner James Goddard, M. D., said it would result in "an encroachment on the practice of medicine in such a way that I believe the physicians of this country would rise up in wrath." He also said:

"In essence the bill would impose upon the formulary committee the duty of evaluating every prescription drug used in medical practice today—more than 5,000—and of providing a formulary of the drugs of choice. I would have to exclude drugs deemed unnecessary, therapeutically duplicative, or of unacceptable quality. The enormity of such a task should be borne in mind."

C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, joined Goddard and John W. Gardner, Secretary of Health, Education and Welfare, in urging that action on the matter be postponed until a report is made on a special study being conducted by HEW. The report is due December 1.

Stetler said the drug industry recognizes the government's responsibility to control federal expenditure in its drug purchase programs. But, he said, Long's proposal put such a low ceiling on drug prices that it would "jeopardize the ability of quality, research-oriented pharmaceutical companies to perform effectively."

"The health of all of us and of future generations is dependent on the continued growth and vitality of a progressive and successful pharmaceutical industry," he said.

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Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.

Dosage: 50-200 mg. (¾-3 grains) at bedtime.

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The Vanishing GP

A recent survey by the *Boston Globe* revealed the surprising fact that not a single member of the present graduating classes of Boston's three medical schools—Harvard, Tufts, and Boston University—plans to enter general practice. Every one of the 332 fourth year students in those schools will enter training for specialty practice upon graduating in June. The Globe's medical reporter properly looks upon this as startling evidence that the family doctor is a disappearing American breed, particularly in view of the fact that two of the schools, Tufts and B. U., have long had national reputations for training general practitioners. The absence of GP candidates among this group of senior medical students came to light when the editors of the Globe sought to explore the motivations of a young doctor about to enter general practice.

Surveys show that only 15 per cent of all doctors are currently engaged in general practice, contrasted with over 50 per cent prior to World War II. By 1970 it is expected that the number will be down to 10 per cent.

There is very little in the current medical educational curriculum to interest or stimulate a budding physician in the problems of family practice. The medical teacher of today, primarily a medical scientist, teaches what he knows best and thus creates new doctors in his own image. The young candidate fears that he will be downgrading himself if he enters general practice, particularly if he goes to a small town.

He hears and reads disparaging views about independent individual practice. The wave of the future, he is told, is in group practice or academic medicine. Nothing in his experience or in his educational environment suggests an opposing view. In fact, discouragement is everywhere.

Something important and worthwhile is disappearing from the American medical scene. We do not feel that we have an answer.—Rhode Island Medical Journal.

Syntex Laboratories Starts Speakers Bureau

Syntex Laboratories of Palo Alto, California, has organized a nationwide speakers service.

Speakers are available to state and county medical groups for their programs or to accept speaking engagements arranged by these organizations or their members.

The subject of the first program is "Two's Company, Three Billion's a Crowd." It deals with the population explosion.

Interested persons may contact the Syntex Speaker Service, Public Relations Department, Syntex Laboratories, Inc., Palo Alto, California.

Change of Address

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HUNTINGTON, WEST VIRGINIA

Obituaries

DAVID M. ROBINSON, M. D.

Dr. David M. Robinson of Bridgeport died unexpectedly on September 17 while playing golf at the Bridgeport Country Club. He was 44.

A native of Sutton, Doctor Robinson attended West Virginia University and received his M. D. degree in 1951 from Jefferson Medical College of Philadelphia. After serving his internship at Methodist Hospital in Indianapolis, Indiana, Doctor Robinson entered private practice in Bridgeport in 1952.

He was a member of the Harrison County Medical Society, the West Virginia State Medical Association and the American Medical Association. During World War II, he served as a navigator in the U. S. Army Air Corps.

Survivors include the mother; the widow, Mrs. Helen M. Tratch Robinson; a daughter, Saundra Jean, at home; two sons, David M., II, and James W., both at home; and two sisters, Mrs. W. G. Reppard of Maryland; and Mrs. L. L. Pierce of Alexandria, Virginia.

* * * *

CHARLES MORTON SCOTT, M. D.

Dr. Charles M. Scott, President of St. Luke's Hospital in Bluefield, died at his home on September 25 of an apparent heart attack. He was 53.

Doctor Scott had recently undergone arterial surgery at the University of Virginia Medical Center and was recuperating at home.

A son of the late Dr. Charles Matthew Scott, the founder of St. Luke's Hospital, Doctor Scott was born in Bluefield. He attended Harvard and received his M. D. degree in 1940 from the Medical College of Virginia.

He specialized in general surgery, and was a Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons. At the time of his death, he was ACS Governor for West Virginia.

Doctor Scott was a member of the Mercer County Medical Society, which he once served as President; the West Virginia State Medical Association; the American Medical Association; and several other medical and surgical groups. In the State Medical Association, he was Chairman of the Federal Medical Activities Subcommittee of the Medical Economics Committee and was a member of the Committee on Military Medical Affairs.

During World War II, he served as a Captain in the Medical Corps of the U. S. Army.

Survivors include the widow, the former Frances Elizabeth Walker; two sons, Charles Matthew, a student at Harvard, and William Wade Walker, at home; two daughters, Janet, a student at the University of Colorado, and Alice, a student at Hannah Moore Acad-

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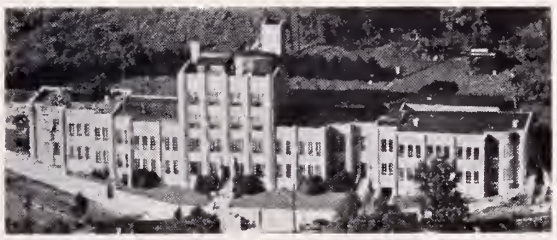

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S. D. WU, M. D.

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RAYMOND W. CRONLUND, M. D.

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JOHN E. LENOX, M. D.
ERNEST G. GUY, M. D.
JAMES M. CARHART, M. D.
KARL J. MYERS, JR., M. D.

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G. E. HARTLE, M. D.

Dentistry:
GLENN B. POLING, D. D. S.

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REZIN DEVER STOUT, M. D.

Dr. R. D. Stout, 82, of Grafton, died in a Grafton hospital on September 15 after a long illness.

Doctor Stout was born in Barbour County and received his M. D. degree in 1910 from the Medical College of Virginia. He was an eye, ear, nose and throat specialist.

Doctor Stout was an honorary member of the Taylor County Medical Society, of which he was a Past President; the West Virginia State Medical Association; and the American Medical Association.

In 1924, Doctor Stout located his practice in Grafton. He was also a physician for the West Virginia Industrial School for Boys for 33 years and served as Taylor County and Grafton health officer for 28 years.

Survivors include the widow, the former Mary Elizabeth Smith of Flemington; one daughter, Mrs. C. H. Sullivan of Basking Ridge, New Jersey; one son, Robert D. Stout of Bennington, Vermont; six grandchildren; one brother, Lloyd Stout of Philippi; one half-brother, Harter Stout of Ravenna, Ohio; and half-sisters, Mrs. William Reed of California, Mrs. Charles Young of Oklahoma, Mrs. Graydon Browning of Ohio, and Mrs. Russell Bishop of Clarksburg.

World Medical Association Welcomes New Members

The World Medical Association, with offices in New York City, announced recently it would welcome membership applications from all members of the American Medical Association.

Dr. Alberto Z. Romualdez, Secretary General, said the WMA has become a strong factor in protecting and promoting the professional interests of the medical profession and the cause of world peace.

Now in its 20th year, the WMA is a federation of the most representative national medical associations in 60 nations. These member associations represent more than 700,000 physicians, or a substantial majority of all the scientifically trained physicians in the world.

WMA is involved in various medical projects and engages in many activities which contribute to a better understanding among the peoples of the world. For example, WMA assists traveling physicians by providing them with introductions to colleagues in other countries, by informing them of medical meetings they may attend while abroad, and by acquainting them with visiting doctors from other countries.

The organization publishes a journal in English, French and Spanish. Dues are $10 a year, which includes a subscription to one of the journals.

Additional information may be obtained by writing to the World Medical Association, 10 Columbus Circle, New York, New York 10019.

County Societies

CENTRAL WEST VIRGINIA

Dr. Richard V. Lynch, Jr., of Clarksburg, President of the West Virginia State Medical Association, was guest speaker at a meeting of the Central West Virginia Medical Society which was held at West Virginia Wesleyan College in Buckhannon on October 4.

Doctor Lynch discussed the State Medical Association's postgraduate medical education program and also that of the Regional Heart Disease, Cancer and Stroke Program.

Dr. Robert L. Chamberlain of Buckhannon, longtime Secretary-Treasurer of the Central West Virginia Medical Society, was elected President for the coming year, succeeding Dr. George T. Hoylman of Gassaway.

Dr. Joseph B. Reed of Buckhannon will succeed Doctor Chamberlain as Secretary-Treasurer.

* * * *

HARRISON

Dr. Richard V. Lynch, Jr., of Clarksburg, President of the West Virginia State Medical Association, was guest speaker at a meeting of his own Harrison County Medical Society at the Stonewall Jackson Hotel in Clarksburg on September 7.

Dr. Andrew Weaver of Clarksburg, Program Chairman, introduced Doctor Lynch, who discussed the 100th anniversary year of the West Virginia State Medical Association. He also stressed the need to make certain changes to meet changing needs in the medical field.

After the meeting, a reception honoring Doctor Lynch was given at the home of Dr. and Mrs. George F. Evans of Clarksburg, Editor of *The Journal* and a Past President of the Association.

* * * *

McDOWELL

The regular monthly meeting of the McDowell County Medical Society was held at Grace Hospital in Welch on September 13.

Dr. Ray E. Burger was in charge of the program and presented a film on "Visceral Organ Transplant."

Dr. J. H. Murry, Health Officer for McDowell County, discussed the Home Health Service which has been in effect for almost a year. He also discussed the Measles Drive and stated that vaccine would be furnished by the Health Department.

Doctor Stephen Mamick presided at the meeting which was attended by 13 members and three guests—Joseph C. Ray, M. D., Secretary.

* * * *

MERCER

Dr. Cooper Bell, Associate Professor of Surgery at the Medical College of Virginia in Richmond, presented the scientific program at the regular monthly meeting of the Mercer County Medical Society, which

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Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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*Stein, I.D.: Presented at the American Academy of General Practice, Dallas, Sept. 1967.

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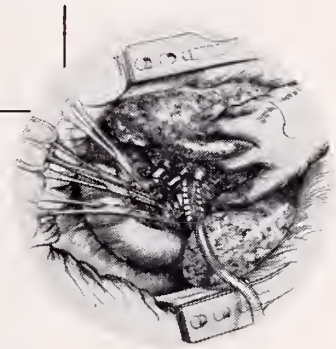

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was held at the West Virginian Hotel in Bluefield on September 18.

Doctor Bell gave a very interesting talk on ulcerative colitis, its course and treatment. His talk was illustrated by slides, and a question-and-answer period followed.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

Professor Benjamin Linsky, Professor of Sanitary Engineering at West Virginia University, was guest speaker at the regular monthly meeting of the Monongalia County Medical Society, which was held on September 5 in Morgantown.

Professor Linsky's discussion of air pollution was followed by a question-and-answer period.

Four physicians were elected to active membership in the Society, while one was admitted to associate membership.

Twenty-eight members and three guests attended the meeting.—Robert Greco, M. D., Secretary.

* * * *

RALEIGH

Dr. Edmund B. Flink, Chairman of the Department of Medicine at the West Virginia University Medical Center, presented the scientific program at the regular monthly meeting of the Raleigh County Medical Society, which was held at Henry's Drive Inn in Beckley on September 21.

Dr. Flink discussed "Etiology and Treatment of Hyponatremia and Hypernatremia."

The Society admitted to membership Dr. David Campbell Meek, a transfer from the medical society in Memphis, Tennessee.

Sixty-three members and guests were in attendance at the meeting.—Forest A. Cornwell, M. D., Secretary.

Polio Virtually Wiped Out In United States

Polio cases throughout the United States were down to 15 during the first seven months of 1967, virtually a 100 per cent drop in incidence since Salk vaccine was first used in 1955.

This represents the lowest national total on record, with only 10 states involved so far.

The Health Insurance Institute, citing United States Public Health Service reports, said 13 of the victims had contracted paralytic polio.

The peak year for the often-crippling disease was 1952, when 57,879 cases were reported. Since then, the Salk vaccine, and the Sabin vaccine, introduced in 1961, have all but eliminated the polio threat in this country. In 1955, 28,985 cases were reported.

Following are the numbers of cases of polio for each year in the United States since 1955:

1955, 28,985; 1956, 15,140; 1957, 5,485; 1958, 5,787; 1959, 8,425; 1960, 3,190; 1961, 1,312; 1962, 910; 1963, 499; 1964, 122; 1965, 72; and 1966, 99.

Woman's Auxiliary

to the

WEST VIRGINIA STATE MEDICAL ASSOCIATION

President: Mrs. Rupert W. Powell, Fairmont
President Elect: Mrs. J. A. B. Holt, Charleston
First Vice President: Mrs. Ray S. Greco, Weirton
Second Vice President: Mrs. Warren D. Elliott, Beckley
Third Vice President: Mrs. Robert G. Janes, Fairmont
Fourth Vice President: Mrs. M. Bruce Martin, Huntington
Treasurer: Mrs. J. Dennis Kugel, Charleston
Recording Secretary: Mrs. Richard G. Starr, Beckley
Corresponding Secretary: Mrs. George A. Curry, Morgantown
Parliamentarian: Mrs. Pat A. Tuckwiller, Charleston

FALL CONFERENCE AND BOARD MEETING

The colorful and historic West Virginia State 4-H Camp at Jackson's Mill was the scene of the Fall Conference and Board of Directors' Meeting of the Woman's Auxiliary to the West Virginia State Medical Association, October 3-4.

Mrs. Rupert W. Powell of Fairmont, the President, presided at the two-day session which was attended by 37 members of the Auxiliary.

Dr. Richard V. Lynch, Jr., of Clarksburg, President of the West Virginia State Medical Association, was the guest speaker and he spoke on the subject of "You and Politics." He stressed the need for personal involvement in politics. He defined politics as the method or methods of governing a group and the method or methods of governing an area with its inhabitants.

"When we realize that 50 per cent of the legislation of the 89th Congress dealt with some phase of medicine," Doctor Lynch said, "it is time we learned more about politics on all levels—city, state and national."

Doctor Lynch's address was preceded by a film outlining the responsibility of the Auxiliary member in connection with AMPAC and WESPAC.

Mrs. John A. B. Holt of Charleston, President Elect and Chairman of the Membership Committee, presented a report of the National Auxiliary Conference scheduled to be held in Chicago in October. Mrs. Wilson P. Smith of Huntington, Chairman of AMA-ERF for the Eastern Region of the United States, presented a brief summary of the workshop scheduled to be held in October.

Committee chairmen and presidents of county auxiliaries presented reports. It was announced that the Spring Board Meeting would be held in Fairmont, April 16-17.

A feature of the Conference was a tour of the Weston State Rehabilitation Center and a visit to the factory of the West Virginia Glass Co. Mrs. Charles T. Lively, President of the Central West Virginia Auxiliary, and Mrs. C. R. Davisson and Mrs. Elden H. Pertz were in charge of arrangements.

Dr. and Mrs. Powell were hosts at a social hour at the new Jackson Lodge preceding a dinner in Mt. Vernon Hall on October 3. Guests included Doctor Lynch, Drs. George T. Hoylman, Robert J. Tchou, Charles T. Lively and C. R. Davisson—Mrs. B. F. Puckett, Chairman, Press and Publicity.

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HARRISON

The Woman's Auxiliary to the Harrison County Medical Society held its regular monthly meeting on Thursday, October 12, 1967, at the Stonewall Jackson Hotel in Clarksburg. Thirty-four members and five guests attended.

Mrs. Lynwood D. Zinn served as chairman of the program, "Introducing Your Harrison County Guidance Center," and introduced the panel of guest speakers: Mr. Donald Fontana, Mental Health Coordinator; Mr. Richard Lockhart, Director of Family Services; Mrs. Shirley Lapeer, Therapist for the Speech and Hearing Clinic; Mrs. K. Estelle Vaughan, Coordinator of the Alcoholism Division; and Mrs. Marian Kniska, Director of the Education Program for Special Students.

Mr. Fontana served as moderator for the panel. Each speaker gave a resume of the primary purposes and responsibilities of his or her division of the Guidance Center in relation to a comprehensive Mental Health Program for the persons seeking aid on the county level. A discussion period followed the program.

Mrs. Hugh M. Brown, president, presided at the business meeting following the program.—Mrs. Robert D. Hess, Press and Publicity.

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KANAWHA

The regular monthly meeting of the Woman's Auxiliary to the Kanawha Medical Society was held at the home of Dr. and Mrs. Henry M. Hills, Jr., in Charleston on October 10.

Guest speakers were Mrs. Alan J. Arthur, Secretary of the Board of Directors for Camp Galahad, and Mrs. John E. Giannakis, Coordinator of the Kanawha County Clothing Chest.

Mrs. Arthur discussed the origin, present problems and future plans of Camp Galahad. Mrs. Giannakis outlined the problems and needs of the Clothing Chest and commended the Auxiliary for its faithful support. The Clothing Chest was established in 1949 by the Auxiliary to aid needy school children.

The following new members were introduced: Mesdames R. S. Birckhead, L. D. Curnutte, and Lewis R. Elias—Mrs. David Bachwitt, Publicity Chairman.

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McDOWELL

Mrs. Warren D. Elliott of Beckley, Second Vice President of the Woman's Auxiliary to the West Virginia State Medical Association, was guest speaker at a luncheon meeting of the Auxiliary to the McDowell County Medical Society, which was held in September at the home of Dr. and Mrs. Louis A. Vega in Welch.

Mrs. Elliott discussed the rise in the venereal disease rate among young people. She asked Auxiliary members to help fight the increasing rate by trying to put educational and instructional material concerning venereal diseases in the schools.

More than 20 members and guests attended the meeting.

MONONGALIA

The Annual Dues Coffee of the Woman's Auxiliary to the Monongalia County Medical Society was held in September at the home of Dr. and Mrs. Robert Greco in Morgantown.

Assisting Mrs. Greco were the following new officers of the Auxiliary: Mrs. Walter H. Moran, Jr., President; Mrs. W. Merle Warman, President Elect; Mrs. Rex B. Conn, Jr., Vice President; Mrs. John H. Wolfe, Jr., Recording Secretary; Mrs. Stephen B. Dewing, Corresponding Secretary; and Mrs. Thomas M. Howes, Treasurer.

Special guests were Mrs. Rupert W. Powell of Fairmont, President of the Woman's Auxiliary to the West Virginia State Medical Association; and Mrs. Robert Janes, also of Fairmont, Third Vice President of the Auxiliary.

* * * *

OHIO

Perhaps even more than in years past, the Woman's Auxiliary to the Ohio County Medical Society is looking forward to an enthusiastic year for the Future Medical Careers Clubs in our high schools. Spurred on by the goals we have already attained, we are encouraged to renew our efforts in response to what seems to be a growing demand for information regarding the medical field and the funds with which to enter it.

Since the organization of our high school's Medical Careers Clubs, there has been a definite increase in the number of students, particularly among the girls, who enter the various medical fields. This fact, confirmed by nursing school administrators and high school counselors, emphasizes the importance of exposing these young students to the many facets of the medical world.

Our Health Careers Clubs membership last year numbered, in our four high schools, more than 200 students. Its members logged 10,762 hours of service to our two hospitals. In addition to this "Candy Striper" program, they made tray favors for patients; gave a Halloween party for an orphanage; sponsored a booth in the Health Fair; aided shut-ins with special services such as hair-care and the writing of letters; and collected magazines for the hospitals.

These young people are presented with 20 different programs in a three-year period. Speakers are provided by the local hospitals, clinics, agencies and homes. Field trips are made whenever practical and possible—such as the one made every two years to the West Virginia University Medical Center. Other trips have included the observation of speech therapy classes and tours of special departments in our local hospitals.

The effect of this exposure and the subsequent desire of so many members of these clubs to join the medical world has inevitably also led to the first complete depletion of our Careers Loan Fund. For us, the sponsoring Auxiliary members, we feel that these young people are returning to us the challenge we have thrown to them.—Mrs. William H. Park, President.

Book Reviews

LEARNING MEDICAL TERMINOLOGY STEP BY STEP—By Clara Gene Young and James D. Barger, M. D., F. A. C. P., Pathologist, Las Vegas, Nevada. The C. V. Mosby Co., St. Louis. 1967. Pp. 327. Illustrated. Price: $7.50.

This 300-page book by Young and Barger is a complete review of an earlier publication in 1964. The book presents a logical and organized method of unlocking the mysteries of medical terms, and for building a workable medical vocabulary applicable to all specialties of medicine.

There is a breakdown of medical terms, root prefixes and suffixes into Latin or Greek derivatives. Each body system is discussed briefly, following which there is an extensive glossary dealing with anatomy, physiology, operations, diseases and special descriptive terms applicable to the system.

All sections are arranged alphabetically. There are chapters on abbreviations, and other sections on proper treatment for various hospital forms such as admission, discharge, consultation, operation, history and physical examinations. Satisfactory methods for reporting x-rays, ECGs, autopsies, etc. are included. There also is defined and illustrated the usual forms for insurance and Medicare billing.

The book should be of great interest to the office assistant who has had no formal training. For the experienced secretary there is much information that should lead to a better and wider understanding of medicine by non-medical people.

As stated in the preface it is not designed to replace the medical dictionary.

Chest Physicians Plan Interim Meeting

The American College of Chest Physicians will hold its Interim Clinical Meeting at the Warwick Hotel in Houston, Texas, November 25-26.

As usual, the meeting will precede that of the American Medical Association.

The meeting will consist of a two-day scientific program with roundtable discussions and fireside conferences. A highlight of the program will be a panel discussion held at the NASA Manned Spacecraft Center.

The subject of the panel will be "Cardiorespiratory System and Space Flight," and Dr. Charles A. Berry, Chief of Center Medical Programs, will serve as Moderator.

Administrative and Committee meetings will be held on Monday, November 27.

A copy of the program and other details may be obtained by writing to the Executive Office of the American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois 60611.

The West Virginia Medical Journal

Vol. 63, No. 12 December, 1967

The Drug Problem Among Young People*

Dana L. Farnsworth, M. D.

The current publicity attending the unauthorized use of drugs by young people has convinced the general public that drug taking is a new problem. It is not. For thousands of years, alcohol, peyote, marijuana, hashish, opium and other substances which produce similar effects (such as laughing gas [nitrous oxide], ether and glue solvents) have been used to alter human consciousness and distort the ordinary sense of, and responses to, reality. What *is* new, however, is the high incidence of young people participating in "the drug scene" and the extent of acceptance or encouragement of it by influential members of the literary and academic worlds.

Of all the hallucinogenic agents, LSD (lysergic acid diethylamide) and marijuana (cannabis) are at present the most widely used. Less extensive use is made of mescaline, bufotenine, psilocybin and demethyltryptamine.

The pharmacological qualities of LSD are discussed in a recent article by the Committee on Alcohol and Drug Dependence of the AMA Council on Mental Health.[1] As yet, research has not established LSD as an effective treatment for any disorder. Such research, however, is gravely handicapped by emotional reactions toward the drug engendered by its irresponsible and illicit use.

The chief objection to the use of LSD arises from the growing body of evidence that it produces irreversible changes in the life style and personality of those who use it. Physiological changes are suggested in Cohen's work on chromosomal disruption.[2]

Psychological changes usually include impairment of the subject's ability to make realistic judgments. An individual who is under the influence of LSD can ignore facts previously held to be valid and construct new beliefs, no matter how irrational. Such forms of thinking bear much similarity to psychosis. A person may feel that he has powers which he did not previously have, or that certain laws of the environment (such as vulnerability) are not operative in his case. For example, feeling omnipotent, he believes that he can jump out of a window without being hurt. Wishful thinking becomes prominent. Preoccupation with isolated aspects of sensory experiences may replace all other sensations. Most characteristic of all is the abandoning of long-term patterns of striving, which Freedman and Powelson[3] describe as follows:

> "LSD enthusiasts talk of religious conversions, the awakening of artistic creativity, the reconciliation of opposites. The main change to be observed in such individuals, however, is that they have stopped doing anything. The aspiring painter talks of the heightening of his aesthetic sensibilities and skills, but he has stopped painting. The graduate student who withdrew from writing his dissertation in philosophy talks of the wondrous philosophical theories he has evolved. But nothing is written. It seems that the world of fantasy has become far more compelling than external things. Indeed, fantasy is substituted for reality."

One enthusiastic user of LSD and marijuana says, "It has been .....'s experience, and many others, including my own, that the mind-drugs, the hallucinogens, do very interesting and wonderful things and greatly open the mind to the creative processes." To an observer he appears

The Author

- **Dana L. Farnsworth, M. D., Director, University Health Services and Henry K. Oliver Professor of Hygiene, Harvard University, Cambridge, Massachusetts.**

***Presented before the second general scientific session of the 100th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25, 1967.**

to have abandoned the usual efforts to be clean, neat and presentable; he has failed in college, has no job (and doesn't want one), yet insists that he has achieved happiness. Like many other users of the hallucinogenic drugs, he insists that physicians who take care of those who become disturbed or psychotic know nothing about the drugs, refuse to see their good qualities, and are in no position to judge them because they have not taken them themselves. Clinical reports of persons involved in acute and chronic psychoses, suicide, or even murder are discounted by the more ardent advocates of drug usage as being so few in number as to be insignificant.

In the past, most users of illegal drugs had deprived socio-economic backgrounds and poor social and educational records, a tendency to criminal behavior, and preferred narcotics to other drugs. In general, the new users come from the middle class, have had good educational experiences, and often are involved in intellectual or creative pursuits. When drug use changes their attitude and capacity for judgment, the differences are much more noticeable than they are in the more deprived groups.

The evidence of harmful effects of marijuana is less clear than that of LSD. In fact, many people insist that its use has no disadvantages other than being illegal, and some groups are campaigning vigorously for legalization of marijuana. A comprehensive presentation of the proponents' arguments appears in Ginsberg's[4] *Atlantic Monthly* article "The Great Marijuana Hoax."

On the other hand, there are those who maintain that marijuana's dangers go beyond the legal ones. As with the drug's advocates, its opponents' points of view constitute a spectrum, with some objecting on moral grounds, some on the basis of its psychological and physiological effects, and some who do not oppose use of marijuana *per se* but interpret it as a sign of young people's personal and societal difficulties and an unconscious call for help.

Keeler[5] has reported 11 instances of adverse reactions to marijuana. Some of them were of psychotic proportions and included panic, fear, depersonalization, gross confusion and disorientation, depression, and paranoid reactions. Four subjects became schizophrenic (with thinking disorders and inappropriate affect) after extensive use of marijuana, amphetamine and LSD. Keeler is of the opinion that marijuana can produce psychotic disorders of a serious degree and that its use can initiate destructive changes in life style. When there are differences of opinion on this latter point, the "patient" approves the change but most other persons do not.

My experience, and that of my colleagues at the Harvard University Health Services, support the contention that the use of marijuana does indeed entail risk. In fact, we find it to be harmful in many ways and to lack counterbalancing beneficial effects. Many students continue to think it is beneficial even while their grades go down and while other signs of decrease in responsible and effective behavior become apparent.

Some Characteristic Complications

A few characteristic complications of marijuana usage will serve to illustrate our concern:

A 21-year-old woman was involved in a conflict with her mother regarding choice of serious dating partners, following which she renounced her religion, drank to excess, and became promiscuous. When she became fearful of the effects of drinking she began smoking marijuana regularly. She then became depressed. To combat her depression she used more and more marijuana and, on one occasion, after smoking an unusual amount, slashed her wrists and was admitted to a hospital. Under psychotherapy she improved, stopped using drugs, and resumed effective academic work.

A 19-year-old man with high moral standards became depressed, used marijuana to combat an acute depressive episode, experienced "black despair," and then obtained sedative pills from a friend which he took in an attempt at suicide. After admission to a hospital and subsequent treatment for his depression, he improved and has resumed his studies.

A 20-year-old woman with a long history of emotional conflict became socially irresponsible, intermittently depressed and occasionally overactive and irritable. She tried marijuana to combat her symptoms but found that it was not giving her the "kick" she had sought. On the advice of friends, she began taking LSD with the hope that it would enable her to gain insight and become more aware of herself. Her potentially disastrous behavior continues and psychotherapy is refused.

A 19-year-old man with dirty clothes, unkempt hair and beard, in conflict with his parents, hopeless about society, has been taking benzedrine, dexedrine, marijuana and LSD, "to find out about himself." He views those who encourage him to avoid drugs as part of the hostile establishment who are infringing on his rights. His use of drugs serves as a barrier against development of the kind of satisfying interpersonal relations he desires as well as an obstacle to psychotherapy.

A senior premedical student with an excellent academic record, already admitted to a medical school, suddenly began to do failing work in one course. He said his energy had been diverted into trying to stop using marijuana, which he had begun using extensively during his senior year. When faced with the necessity of studying he found it easier to "take pot." Under its influence he was convinced that studying for examinations was not as important as other things. He wanted help, stating explicitly that he considered the use of marijuana harmful because it encouraged him as well as his friends who used it to "evade reality and pursue illusory goals."

Another student denied that his extensive use of marijuana adversely affected his academic performance, but said that while under its influence he lost both the desire and ability to study. At the end of the semester his grades dropped precipitously. He refused psychiatric help, saying that although he knew he had an emotional problem, drugs had nothing to do with his academic difficulties. Whether or not he is right cannot be proven at present, nor is it relevant, since he is in trouble and does need some kind of help.

These cases illustrate some of the issues involved in the great marijuana debate. In no instance did marijuana cause the original conflict. On the other hand, it contributed nothing positive and probably added to the problems each person faced; indeed, it may have delayed or prevented effective approaches to the solution of their conflicts.

In one sense, it is misleading to talk about "the drug problem" as if it were an isolated phenomenon for, in fact, it is only one aspect of young people's position in contemporary society. If drug taking were not related to current social conditions and individuals' reactions to them, it would be much easier to deal with. But the issues are complex; that is, drug taking *means* something.

Fashionable Aspect

Undoubtedly, fashion has something to do with drug use. In some circles, and particularly among the young, experience with drugs has become a kind of social currency, a source of status and esteem. It is possible, therefore, that if drug taking were no longer condoned by most young people, the users, deprived of the gratification of peer approval, would turn to other (ideally more constructive) methods of dealing with their personal problems.

But if there were not more fundamental factors at work, drug taking would go the way of goldfish swallowing and telephone booth cramming. The fact that drug taking is illegal reveals its function as a form of rebellion and protest—and it is tempting to write it off as such—that is, as a typical "phase" of youth which should be ignored because its passing is inevitable, or treated with a get-tough policy. It would be wrongheaded, however, to do so; young people's rebellion is meaningful to them, and constitutes both a response to their situation and a way of dealing with it. Furthermore, their judgments often are more valid than older generations care to admit.

On a personal level, young people tend to suffer intense feelings of isolation and vulnerability. Present-day American society and its institutions often exacerbate these feelings. For example, the mass-produced is valued more, the man-made less than ever; both the government and colleges are becoming larger and more impersonal; and the individual's sense of being insignificant and helpless is increasing.

The process of attaining skill in the trades and professions seems to them at least uncomfortably long and sometimes irrelevant to their future activities. For many members of minority groups it is impossible. School is the only place most young people can be sent for training. When school programs are imaginative, relevant to past experiences and future expectations, and led by teachers whom the students can like and respect, students participate with enthusiasm. When curricula are dull, teachers uninspired, listless, underpaid and overworked, physical facilities inadequate, and support from parents and the community lacking, the students can hardly be expected to be enthusiastic about their education.

Moreover, young people are keenly aware of social injustice, the threat of nuclear war, and the ineffectiveness or downright hypocrisy of many of those in authority. They are confused about authority, not clearly appreciating that responsible authority permits a democracy to exist whereas irresponsible authority, or authoritarianism, is destructive of the democratic process. As a result of their confusion they often tend to reject all authority. Sometimes their criticisms of society become so generalized that they reject most conventional values, refuse to participate in a system they see as pernicious, and focus instead, with drugs as their instrument, on their own subjective values and experience; this is the meaning of the phrase *turn on, tune in, drop out*, (e. g., marijuana often seems to them to produce a sense of greater fellow-feeling and better communication).

Because of their psychological effects, drugs temporarily help young people to escape their feelings of being alienated, under pressure, and helpless; simultaneously, the act of drug taking places each individual in a group of kindred spirits. He may feel better related to others even as objective observation shows him to be even more isolated than before.

Many young persons have not had the advantage of a family life in which they were trained for responsibility. One group of young former drug takers who appeared on a David Susskind show agreed that if their parents had been concerned about them and had been strict in setting standards for them to follow, the possibility of their becoming dependent on drugs would have been decreased. In their discussion they formulated the principle that concern without discipline is of little value and discipline by parents who do not really care about their children is useless.

Drug use and its associated forms of behavior have certain built-in limitations. They provide little permanent satisfaction. Short-range satisfaction is derived from peer group approval and publicity. Moreover, the overzealous (and sometimes blatantly wrong) activity of some law enforcement officials serves as justification or "proof" of the rightness of their own positions. The exaggerated concern accorded them by their frustrated and bewildered critics may encourage them to persist with their self-defeating activities longer than they otherwise would prefer. Since most of them seem to have no fixed income other than what they get from their families, and are not developing a capacity for responsible employment, they may ultimately tire of their vagabond existence. There is considerable evidence that many young people toy with various forms of asocial or antisocial behavior only to return to more responsible modes of living, often with strong dedication to the righting of social wrongs.

The methods by which alienated young people choose to show their disdain for conventional values make rational thinking about their behavior difficult for older people. Whereas the young usually put high priority on love, peace, idealism, and similar attributes, their appearance and behavior often seem to be peculiarly designed to attract criticism. Long hair, outlandish fashions, lack of cleanliness, sexual laxity, disrespect for personal and public property, and a manner which appears arrogant and impulse-ridden frequently accompany experimentation with drugs. Irritation with specific forms of disapproved behavior tends to divert attention from the fundamental problem, i.e., the dissatisfaction of these people with the values they observe and their subsequent alienation, and direct it toward changing or forbidding the behavior considered undesirable. Attention to the reasons for alienation and disenchantment, if it is to be effective, must include respect for the individuals involved, and tolerance (but not necessarily approval) for their behavior.

The Physician's Role

In their desire to express themselves the majority find satisfaction in their studies, their school associations, and the support they get from their families and friends. Others not so fortunately situated cannot resolve their conflicts (usually they are not even aware of what the conflicts are) and express themselves in delinquent acts, or poorly controlled impulse expression, or by showing no sense of social responsibility (or any combination of these). An even more serious result of the failure to develop a way of life that yields satisfaction is the development of mental or emotional illness. A new and disturbing aspect of hallucinogenic drugs is that they may permanently impair the judgment of people who experiment with them. These potentially capable young men and women could thus become permanent casualties of their struggle to give meaning to their existence, and we should find methods of preventing such a disaster if possible. Physicians are in a particularly good position to help educators develop such methods and should, therefore, acquaint themselves with the issues involved.

If we approach the solution of the drug problem with single-minded determination to eliminate the drugs, or prevent their use by young people, we run the risk of adding to our difficulties rather than minimizing them. Drugs should be viewed as an incidental factor, considered in the same class as other forms of "acting-out" behavior (disrespect for property, acting on impulse, accident proneness, delinquency), and not as the central problem. This does not lessen the importance of appropriate laws for the control of potentially harmful drugs and support of law enforcement agencies. In showing such support, however, the physician should not be the punitive agent, thus depriving troubled people, who happen to use drugs as one of their attempts to deal with their conflicts, of one of their sources of effective help.

The American Medical Association, through its Committee on Alcohol and Drug Dependence and the Council on Mental Health, has prepared a series of statements on all the drugs about which medical authorities are concerned.

Those on narcotics,[6] barbiturates,[7], amphetamines,[8] marijuana,[9] and LSD[1] have been pub-

lished in *JAMA*. An extensive monograph on alcoholism and a summarizing statement for the general public about the drug problem have been published separately

Armed with the information contained in these publications, every physician can be of inestimable help to educators, law enforcement officials, clergymen, parents, leaders of young people's organizations, and others in each community who have a responsibility for keeping drug usage within reasonable and appropriate limits. Success in such an endeavor will depend to a large extent on gaining the understanding and support of the vast majority of young people who are interested in approaching the solution of problems facing them in sound and intelligent ways. Giving them the facts in terms that can be clearly understood, without moralizing, in combination with efficient enforcement of the laws covering distribution of these drugs, appears to be our most important weapon.

References

1. Dependence on LSD and Other Hallucinogenic Drugs. Prepared by the AMA Committee on Alcoholism and Drug Dependence and approved by the Council on Mental Health, JAMA 202, No. 1, (Oct. 2) 1967.
2. Cohen, M. M.: The New York Times (March 17) 1967.
3. Freedman M. & Powelson, H.: Drugs on Campus: Turned On and Tuned Out, The Nation (Jan. 31) 1966, pp. 125-127.
4. Ginsberg, A.: The Great Marijuana Hoax, Atlantic Monthly (Nov.) 1966, p. 6.
5. Keeler, M. H.: Adverse Reaction to Marijuana, Am. J. Psychiat., in press, 1967.
6. Narcotics and Medical Practice. The Use of Narcotic Drugs in Medical Practice and the Medical Management of Narcotic Addicts, JAMA 186:976-982 (Sept. 21) 1963.
7. Dependence on Barbiturates and Other Sedative Drugs. Prepared by the AMA Committee on Alcoholism and Addiction, reviewed by the Council on Drugs, and approved by the Council on Mental Health, JAMA 193:673-677 (Aug. 23) 1965.
8. Dependence on Amphetamines and Other Stimulant Drugs. Prepared by the AMA Committee on Alcoholism and Addiction, reviewed by the Council on Drugs, and approved by the Council on Mental Health, JAMA 197:1023-1027 (Sept. 19) 1966.
9. Dependence on Cannabis (Marijuana). Prepared by the AMA Committee on Alcoholism and Drug Dependence (formerly Committee on Alcoholism and Addiction) JAMA 201:108-111 (Aug. 7) 1967.
10. Manual on Alcoholism. Prepared by the AMA Committee on Alcoholism and Addiction, AMA, Chicago, 1967.
11. The Crutch That Cripples: Drug Dependence. Prepared by the AMA Committee on Alcoholism and Drug Dependence, AMA, Chicago, 1967.

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Granulomatous Parotitis

C. T. Yarington, Jr., M. D., Philip M. Sprinkle, M. D., and Stanley W. Gensler, M. D.

INFECTIOUS granulomata of the parotid gland might be termed "granulomatous parotitis" with the understanding that, in many instances, pathology is primarily in the paraparotid lymphatic tissue. This paper will be devoted to a discussion of granulomatous parotitis from the standpoint of differential diagnosis and treatment. A number of cases of granulomatous parotitis secondary to a variety of etiologic agents recently have been encountered by us. The diagnostic and therapeutic problems which these cases engendered and the scant references to this disease entity prompt this discussion.

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Tuberculosis

Tuberculosis is the most frequent cause of specific granulomatous infections of the parotid.[1] Usually the parotid pathology is accompanied by pulmonary disease secondary to Mycobacterium tuberculosis. The typical caseating granulomata, presence of acid-fast staining rods, Langhans giant cells in characteristic radial arrangement, and positive skin testing for tuberculosis, make presumptive diagnosis relatively simple. With culture and innoculation studies, confirmation is easily obtained. Unfortunately, many of these diagnostic findings may not be present in a particular case. Pulmonary disease may be absent; acid-fast rods may be scant and difficult to find on microsocopic examination, and attempts at culture may be unsuccessful. Antituberculous medication is the treatment of choice. Surgery is indicated at times if caseation necrosis occurs, and should be performed under appropriate drug therapy, and complete excision carried out. Incision and drainage is fraught with complications. Despite its supposed frequency, this form of granulomatous parotitis has not been seen by us.

This is the first in a series of articles on salivary gland pathology which will attempt to review the broad spectrum of salivary gland disease including infections, neoplasms and their treatment.

Atypical Acid-Fast Mycobacterium

The problem of atypical acid-fast Mycobacterium (unclassified Mycobacterium, unclassified or atypical tuberculosis) only recently has become well recognized. Although we have experienced a number of cases with this disease in the parotid or paraparotid lymphatic tissue, this problem thus far has escaped the attention of the medical literature.

Atypical Mycobacterial infections are caused by "Battey organisms" (scotochromogens) and, less commonly, by the photochromogens such as Myco. kansasii.[6] These organisms are closely associated with Myco. tuberculosis, and the vast majority will give at least a weakly positive response to PPD-S, or standard PPD, although specific skin tests do exist (PPD-B, PPD-D and PPD-Y). This disease, like tuberculosis, may be a primarily pulmonary infection, or exist as a granulomatous lymphadenitis. Its major difference is its poor response to usual antituberculosis medical therapy. Therapy must be dependent upon sensitivity studies.

Interestingly enough, granulomatous adenitis is common with this disease, and almost always is unilateral and not associated with pulmonary disease. Complete surgical excision of these lesions offers the best prospect of cure, while incomplete excision almost always ends in fistula formation. This has also been our experience with subtotal parotidectomy, resulting in cure of paraparotid atypical mycobacterial infections. The pathology is illustrated in the accompanying figures.

Animal Scratch Disease

This disease, thought to be caused by a virus antigenically related to psittacosis-lymphogranuloma venereum virus, was formerly classified as

Submitted to the Publication Committee, June 30, 1967.

"cat-scratch disease." Now it is recognized that it can occur secondary to scratches from a number of animals. A positive skin test may be obtained from antigen prepared by the Frei procedures from a lymph node of an infected patient. No other certain diagnostic tests exist.[2]

The pathology of this lesion is that of an acute infectious granuloma of the lymphatic tissue in the region of innoculation. Although fever and malaise are associated with the initial infection, the adenopathy may persist for months. The histologic features are illustrated in the

Figure 1. Following isolation of the facial nerve and excision of a diseased superficial lobe, a large granulomatous mass is seen bulging out from beneath the mandibular branch of the nerve. A case of animal scratch disease.

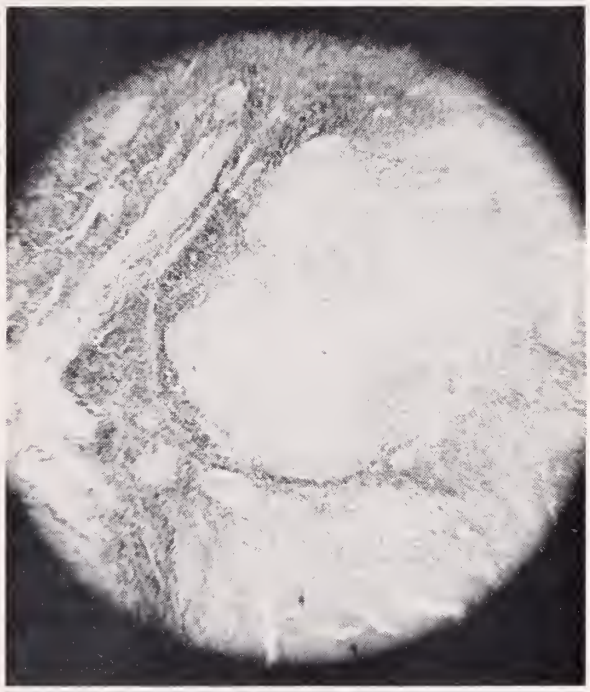

Figure 3. Medium power H. and E. stain photomicrograph of an acute granuloma seen with animal scratch disease of the parotid. Note lack of cascation or fibrous elements.

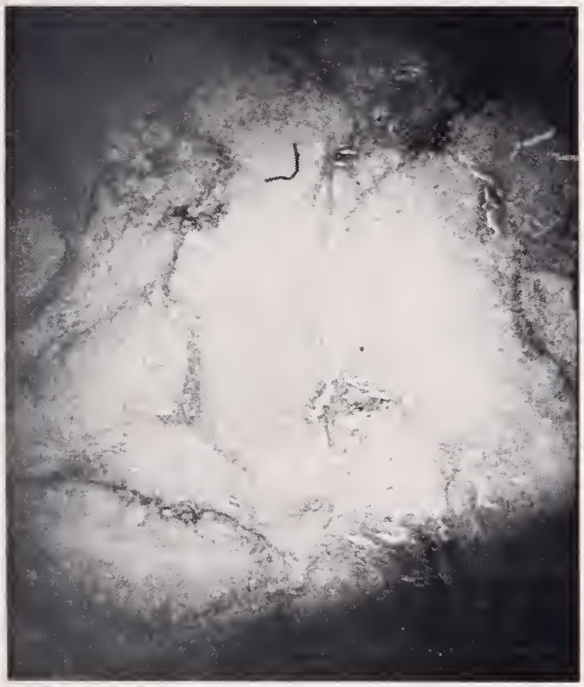

Figure 2. Low power H. and E. stain photomicrograph showing typical caseating granulomata seen with either tuberculosis or atypical Mycobacterial infections of the parotid. This section is of an atypical Mycobacterial granuloma.

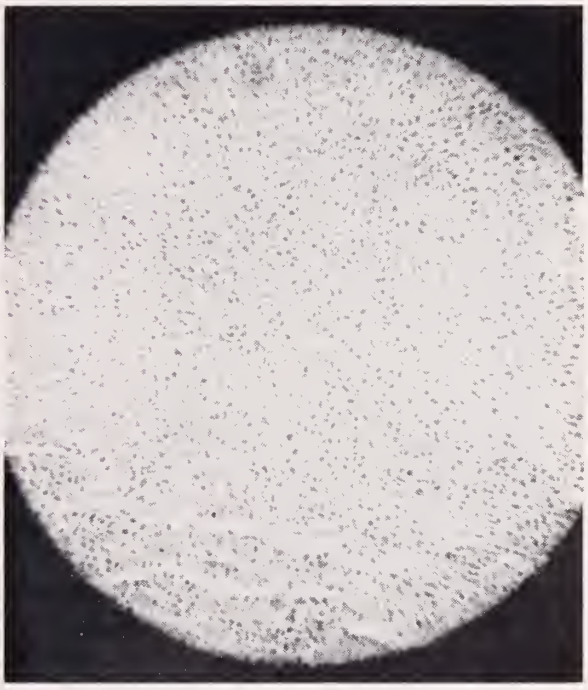

Figure 4. High power H. and E. stain photomicrograph showing the histiocytic inflammatory cell infiltrate characteristic of acute infectious granulomata. Etiologic agent identification will determine fungal disease as opposed to viral animal scratch disease.

figures. This disease is being seen with increasing frequency in the parotid area. Three of four cases reported by Blatt[3] responded to subtotal parotidectomy, while the fourth responded to antibiotic therapy. In general, this disease resolves spontaneously with time, although broad spectrum antibiotics may be of some value. In our experience, however, the rapid appearance of a firm mass in the parotid which persists despite conservative therapy, should prompt consideration of surgery. We have found subtotal parotidectomy, with early and complete isolation of the facial nerve, to be curative without morbidity. Granting that conservative therapy and watchful waiting have their place in this disease, surgery seems indicated when the parotid is involved due to the difficulty in clinical differentiation from neoplasm.

Tularemia

Tularemia (rabbit fever) caused by Pasteurella tularensis has been mentioned as a cause of granulomatous parotitis.[4] This disease usually is associated with a local lesion at the site of innoculation which ulcerates as the patient incurs the systemic signs of the disease. Skin tests, serum agglutination studies, cultures and laboratory innoculation confirm the diagnosis.[2]

This serious systemic disease usually is treated with Streptomycin or broad spectrum antibiotics. It usually is not a surgical diagnostic problem in the parotid, due to the many diagnostic methods available. It would seem that intensive medical therapy would be the treatment of choice.

Actinomycosis

Actinomycosis also may cause infectious granulomata of the parotid of a chronic type, and usually is caused by the anaerobic Actinomyces bovis, easily identified as the yellow "sulfur crystals" in the tissue or pus. Numerous draining sinuses frequently occur with woody induration of the gland.

Culture of the organism or identification of the organism in the pus or tissue are the methods of diagnosis. Treatment with Stilbamidine and various broad spectrum antibiotics has been effective,[2] although penicillin is considered the drug of choice.[5] Here again, intensive medical therapy is the treatment of choice, while surgery seldom is curative, and subject to many complications.

Histoplasmosis

Infection of the parotid due to Histoplasma capsulatum is uncommon and may be easily diagnosed by identification of the organism. Culture, skin tests, biopsy and complement fixation studies are further aids in diagnosis.

Treatment by complete excision is best in localized lesions, but disseminated infections are difficult to treat.

Intensive medical evaluation and therapy are necessary in the disseminated forms of this disease as there is no ideal therapeutic agent available, although Amphotericin B is useful.

Miscellaneous

A variety of other lesions may cause granulomatous reactions in the parotid area. Such problems as leprosy (Hansen's disease) and yaws may cause granulomatous parotitis, but we have had no experience with these lesions and would feel that, as with sarcoidosis, their infectious potentiality is open to question.

Some neoplasms also may manifest themselves clinically as a granuloma and appear granulomatous even on biopsy. This is not unusual with sarcomas or some lymphomas. These lesions, however, are outside the realm of this discussion.

Syphilis does manifest itself by granuloma formation in its late stages while epitheloid hyperplasia may be seen in cervical nodes in early stages. We recently have discussed this problem in the literature in detail.[8] Usually the cervical nodes are affected, and we have not encountered this disease in the parotid region.

Foreign body granulomas have been discussed recently[9] and are treated by excision.

Summary

The problem of infectious granulomata of the parotid gland in the light of our experience and the available literature is discussed. We have avoided mention of Boeck's sarcoidosis,[10] as this has been widely discussed by others, and its infectious potentiality is a matter of conjecture. The problems of atypical Mycobacterial infection, animal scratch disease, and other infectious granulomatous diseases of the parotid which previously have received little notice are discussed.

References

1. Ash, J. E. & Rauhm, M.: An Atlas of Otolaryngic Pathology, Am. Acad. Ophth., p. 458.
2. Nelson, W. E.: Textbook of Pediatrics, Philadelphia, W. B. Saunders Company, ed. 6, pp. 515-518, 417-453, 1954.
3. Blatt, J. M.: Chronic and Recurrent Infections about Salivary Glands with Special Reference to Children, Report of 25 Cases, Laryngol. 76:917-933, 1966.

4. Blatt, J. M.: Systemic Disease of Major Salivary Glands, Tr. Am. Acad. Ophth. & Otolaryng. 69:1115-1121, 1965.
5. Soss, T. L.: Cervicofacial Actinomycosis, Arch. Otolaryng. 81:421, 1965.
6. Curry, F. J.: Atypical Acid Fast Mycobacteria, New England M. J. 272:415-417, 1965.
7. Smith, D. H., Doherty, R. A. & De Lemos, R. A.: Unclassified Mycobacterial Infection and Disease in Children Residing in Massachusetts, J. Pediat. 67: 759-767, 1965.
8. Yarington, C. R., Jr. & Jensen, O.: Syphilis as a Differential Diagnosis in Neck Masses, Arch. Otolaryng. 86: 219-221, 1967.
9. Danforth, H. B. & Brown, A. K.: A Foreign Body Etiology of Pharyngomaxillary Space Abscess, Laryngol. 73:1485-1492, 1963.
10. Yarington, C. T., Jr., Smith, G. S. & Benzmiller, J. A.: Value of Histologic Examination of Tonsils: A Report of Isolated Tonsillar Sarcoidosis, Arch. Otolaryng. 85:680-681, 1967.

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Appalachian Regional Demonstration Health Program*

Daniel Hale, M. D.

THE Appalachian Regional Health Program has been in the press and before the public for over three years. It has its roots in Section 202 of the Appalachian Regional Development Act of 1965. This Act provides for construction of "multi-county demonstration health facilities." Many of you may recall that at the beginning differences of opinion arose as to the exact meaning of this phrase "multi-county demonstration health facilities." As a consequence, a long period of inaction ensued, with little accomplished.

Because of this long delay, the Appalachian Regional Commission, at Governor Smith's insistence, passed a resolution providing for "Quick Start Proposals" by the participating states. In accordance with this resolution, West Virginia prepared and then presented in early January, 1966, a fine proposal for a Multi-County Regional Health Center.

By that time, however, the Commission had appointed a Health Advisory Committee which was instructed to advise the Commission on health matters, to conduct a study into the health needs of Appalachia, to make recommendations for meeting those needs, and to develop Criteria and Guidelines for the establishment of 202 Projects.

The Health Advisory Committee was composed of 25 members, with Dr. Paul A. Miller, then President of West Virginia University, as Chairman, and two representatives from each of the Appalachian states. The governor of each state appointed one representative, and Mr. John Sweeney, the Co-Chairman of the Commission, also appointed a representative from each state. Representatives from West Virginia, besides Doctor Miller, were Dr. Mildred M. Bateman, Mr. Sweeney's appointee; and Dr. N. Allen Dyer, Governor Smith's appointee.

Not long after the Health Advisory Committee had been directed to draw up Criteria and Guidelines for Section 202 of the Appalachian Regional Development Act, the West Virginia "Quick Start Proposal" was presented to the Health Advisory Committee and was rejected because the Proposal did not conform to the Criteria and Guidelines, which, at that time had not yet been written. As a result there followed another prolonged interval of indecision and utter confusion in the Appalachian Health Program, characterized by inaction on a national level; but characterized in West Virginia by strong competition between Mercer, McDowell, and Raleigh Counties for designation as the location of a future Regional Health Center, which was visualized by most people as some sort of giant medical complex rendering comprehensive health services. The competition between these counties at times became spirited and intense; and, very frankly, I feel it influenced the ultimate decisions of both the Governor and the Commission particularly as related to the final interpretation of the principles set forth in the Criteria and Guidelines.

By this time the confusion had been compounded, and the Health Advisory Committee to the Commission, itself, had become controversial, as had the Criteria and Guidelines:

First, the Health Advisory Committee was under attack, and was the subject of dispute from various sources, especially among representatives of organized medicine, because of its makeup. Of its members only seven of the 25 actually lived in Appalachia. All except two or three of its members lived in metropolitan areas such as Pittsburgh, Knoxville, Birmingham and Charleston; and only two came from small towns or rural sections. Only one member was a practicing physician. On the other hand, the Committee's membership contained at least three deans of medical schools or vice presidents of universities and at least four other persons with high level medical school or university affiliation.

Second, the Criteria and Guidelines became controversial because, when they were finally developed by the Health Advisory Committee, they called for "phased development through clearly defined steps of comprehensive health

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***Presented before the 43rd Annual State Health Conference, sponsored by the West Virginia Public Health Association, at the Daniel Boone Hotel in Charleston, May 11-12, 1967.**

Submitted to the Publication Committee, May 15, 1967.

services to all segments of the population in a designated area." As one might expect, this language carried with it many implications, and it became subject to many different interpretations. Naturally, in many parts of Appalachia such a statement stirred up a violent reaction among organized medicine.

Doubts Resolved Through Discussions

But, fortunately for West Virginia, as far as organized medicine was concerned, doubts were largely resolved through frank discussions between proponents of the project and leaders of organized medicine. As a consequence, the program which is presently being finalized has obtained the approval of the Council of the State Medical Association with certain reservations which were readily concurred in by all concerned, including the Commission and the Health Advisory Committee. The West Virginia State Medical Association is the first such group in the country to give its approval to a developing 202 Project. Also, the West Virginia Project now has unanimous approval of the county medical societies in the counties to be served. Undoubtedly, changes in the membership of the Health Advisory Committee—including the addition of more practicing physicians—and a more realistic interpretation of the Criteria and Guidelines by the Health Advisory Committee and its Staff have been at least partially responsible for the favorable reaction among organized medicine in West Virginia.

It is with satisfaction that we, in West Virginia, have overcome opposition from organized medicine because we foresaw the controversy to begin with and, at the start, formulated our program and the structure of our local organizations with the full backing and involvement of organized medicine in order to obviate the same difficulties which were later to appear in other places in Appalachia.

A Rare Opportunity

Having had the personal fortune to have appeared before the full Health Advisory Committee to submit the "Quick Start Proposal" and having had many meetings with members of the Health Advisory Committee and its Staff, and having attended several seminars and regional meetings set up to discuss this program, I personally became convinced—as have other physicians in the Project Area—of the good will and good intentions of the Appalachian Regional Commission, its Health Advisory Committee, and the staffs of both. Not only do we in Southern West Virginia feel that the Appalachian Regional Health Program does not pose a threat to the private sector of medicine, but we also believe that this Act offers a rare opportunity for really significant and massive advances in medical care for this whole region. We have labored with the firm conviction that locally organized County Health Councils working under Section 202 provide a great opportunity to improve present health services and facilities in our State and offer, as well, a chance to fill in the gaps and deficiencies which are so obvious to those of us who practice medicine in the southern part of the State. In fact, we believe this opportunity is the greatest to come our way since the turn of the century and may well be the last chance we will have to reverse the deterioration in medical care which is now going on in this nine-county region by attrition and the changing patterns of medical practice. We are convinced at the same time that this Program offers an opportunity to preserve the free enterprise concept in the practice of medicine as we know it today.

In this particular instance it is my personal belief that practicing physicians in this area now have a great opportunity to show that an innovative and forward-looking program can be channeled in the interest of both the physician and the consumer of medical care.

Bringing The Counties Together

The biggest problem with which we have been confronted, however, has been to come up with a method by which the nine counties in Southern West Virginia could be brought together and organized to present an acceptable Regional Comprehensive Health Demonstration Program, conforming to the Criteria and Guidelines of the Commission. This problem has been almost overwhelming, not only because of the competition and rivalry which previously had been generated by the counties seeking the location of the Regional Health Center, but also because of constantly shifting groundrules governing the content and format of the Plan to be developed. And, frankly, even today, this latter difficulty still plagues us.

Another cause of delay has been that it was only about September 1 of last year that the philosophy underlying the Criteria and Guidelines became clearly defined in terms which, we as practicing physicians, could live with and which, at the same time, would allow us to help formulate an acceptable program.

On October 5, 1966, during a visit by Dr. Charles Boettner, who was the newly selected Executive Secretary of the Health Advisory Committee to the Commission, a group of progressive citizens in Mercer County, including Drs. W. Hampton St. Clair, Frank J. Holroyd, Charles

M. Scott, L. J. Pace, and others actively participating in community affairs, decided that Mercer County should take the initiative in organizing the nine southern counties in West Virginia designated by the Department of Commerce as eligible for an Appalachian 202 Project.

Organizational Meetings

Prominent physicians and citizens in all nine counties were aided in arranging organizational meetings which included representatives of such organizations as county medical societies, nurses' associations, county boards of health, the various hospitals, county boards of education, county courts, local voluntary health agencies and other groups vitally interested in the provision of medical care. Meetings were held with varying degrees of success in Mercer, Summers, Monroe, Raleigh, Fayette, McDowell, Wyoming, Logan and Mingo counties. County Steering Committees were formed. Three members and two alternates were elected from each county organization to form an over-all Southern West Virginia Appalachian Regional Steering Committee for Health. A temporary Regional Steering Committee was first formed in Beckley on October 26, 1966, and later was made permanent in Welch on November 13. The Chairman of the Regional Steering Committee was given the responsibility for the organizational drives leading to the formation of County Steering Committees.

The county committees were divided into the following working groups: public health, mental health, training and manpower, extended care, communications and transportation, dental care and medical services. These groups, or committees, were charged with the responsibility to inventory existing health facilities and services in their respective counties and to determine their county's needs and to make recommendations for improvement. The findings of these Committees were then reported to corresponding regional committees which approached these same problems with a regional outlook and made final reports to the Regional Steering Committee.

Consultants in various disciplines were made available from Johns Hopkins University, the United States Public Health Service, the National Institutes of Mental Health, West Virginia University, the State Health Department, the State Mental Health Department and others. On January 19 a prospectus, or Work Plan, for demonstration health projects for the nine Southern West Virginia counties was presented by the Regional Steering Committee to the Appalachian Regional Commission. This prospectus fully utilized the Regional Technical Committee Reports. Though prepared under pressure and in record time, this prospectus was an effective skeleton around which later were built specific programs and plans which have converted this skeleton into a living, dynamic organism, ready to enhance the health of Southern West Virginia and at the same time preserve traditional patient-doctor relationships.

Development of the Plan

Shortly afterwards, on February 5, 1967, the Southern West Virginia Regional Appalachian Steering Committee voted to incorporate and to become the official administrative body for this program. The committee then contracted with the Department of Commerce to develop, within 60 days, an actual plan for the provision of comprehensive health services as a Demonstration Project for nine Southern West Virginia counties. Immediately the Steering Committee, its regional technical committees, the county steering committees and their county technical committees went to work in the preparation of such a plan. Mr. Ira Southern, of the National Institutes of Mental Health, was designated as Project Coordinator, and Mr. William Crockett, of the State Health Department was chosen as his assistant. Articles of Incorporation were prepared and certified by the Secretary of State, and a Constitution and By-Laws were written and adopted. Thus, this organizational format, established permanent county health councils and a permanent Southern West Virginia Regional Health Council, which will ultimately administer the comprehensive health program.

Three basic principles have been written into the By-Laws governing the Corporation. These principles have been approved by Governor Smith, by Mr. John Sweeney, who was Co-Chairman of the Appalachian Regional Commission, by Doctor Boettner, by Mr. Angus E. Peyton, Commissioner of the State Department of Commerce, and by all members of the Appalachian Regional Steering Committee. These principles are as follows:

(1) The component parts, or county councils, shall be broadly based and must represent a wide variety of organizations and persons interested in medical care, including organized medicine as well as consumers of medical services.

(2) The county councils must be tied in with the power structure of the county, that is, with the elected officials, such as county courts, and

(3) The county councils must have solid backing of organized medicine in their respective counties.

Organization of the county health councils as component parts of an over-all Regional Health

Council is indeed a unique and significant event. Actually, long-term benefits will result from this cooperative effort in which citizens and members of organized medicine have joined in the determination to provide comprehensive health services to their own people. These benefits may well exceed the benefits resulting from the more highly publicized provisions of the Appalachian Regional Development Act. Of additional significance is the fact that this local organizational pattern conforms to the requirements specified by Public Law 89-749, which provides for Regional and State Comprehensive Health Planning.

Delivery of Health Services Challenging

In this connection I shall now digress to emphasize that under this new legislation, dealing with Regional and State Comprehensive Health Planning, the trend in the delivery of health services is challenging. Full involvement of all the people in medicine of the future is clearly at hand. Already "other Appalachias" have been designated for regional planning by the United States Department of Commerce. These regions include the Ozarks with parts of Oklahoma, Arkansas and Missouri; the upper Great Lakes Region with parts of Michigan, Wisconsin and Minnesota; New England with all the New England states involved; the "Four Corners" in the Southwest with segments of Colorado, Arizona, New Mexico and Utah; and the Coastal Plains with the tidewater areas of North Carolina, South Carolina and Georgia. Also mentioned but not yet formally designated is the Mississippi Delta Region.

In addition to these large areas where regional planning is beginning, under the Economic Development Administration virtually the same planning process will take place in relatively smaller groups of counties. More than 75 of these Economic Development Districts are already in various stages of planning, and also the Department of Agriculture is authorizing for both planning and operations Resource Conservation and Development Projects involving multi-county rural and non-metropolitan areas described as "functional rural communities." Twenty-six of these R. C. & D. Projects have already been approved, and it is expected that 15 more will be designated this summer. Thus, we can see that the regional approach to health and other problems with required, active participation by the local people, is the wave of the future. I, therefore, strongly urge other counties in our State to follow the lead of the Southern West Virginia Regional Appalachian Area and immediately organize broadly based county health councils as component parts of a Regional Health Council in order to be ready to ride this wave and take advantage of its benefits.

The organization of such councils can, indeed, be an exhilarating experience. When leaders of the medical profession sit down with other community leaders and sincerely and frankly take inventory of their health facilities and services and ask themselves the question, "What is wrong and how can it be improved?", much good will result from the mutual understanding and awareness which stems from these discussions. The benefits alone, which accrue to the community through this type of organization, are sufficiently great to warrant the effort, even if no other benefits were ever forthcoming.

Now, to return to the subject, in conformity with the agreement between the Southern West Virginia Regional Health Council and the Department of Commerce, a Demonstration Comprehensive Health Program was prepared with the aid of capable professional planners—Mr. I. T. Baldwin, Mr. John Swan and Dr. Joan Lee of Lexington, Kentucky. These professionals in writing the Plan for the Appalachian Regional Demonstration Health Program, again, utilized the material presented by local technical committees. This Plan was presented to the West Virginia Department of Commerce on March 31, 1967. The quality and workmanship of this Plan are matched by only its broad grassroots origin and support and its strong appeal to both the purveyors and the consumers of medical care, both of which factors form the foundation upon which the Plan has been developed.

Revision of Initial Plan

The text of the Plan is currently undergoing minor revision as a result of a pre-evaluation by the staff of the Health Advisory Committee to the Commission; and in keeping with a recent change in policy established by the Appalachian Regional Commission at its May meeting at White Sulphur Springs, West Virginia, the budget dealing with Section 202 of the Appalachian Regional Development Act is also being revised to bring it within the limits stipulated by the Commission. It is our hope that this Project will be formally presented to the Commission by Governor Smith early in June and after appropriate review, we hope that approval will be forthcoming at the August meeting of the Commission.

This Appalachian Regional Health Program is an ambitious one and will have a far greater impact on the economy, health and well-being of the people of southern West Virginia than is generally known. It has been indicated that possibly as much as 20 million dollars under

Section 202, alone may be available to the Project Area for the development of this Program. This amount, however, actually is equivalent to a far greater sum because this 20 million dollars is Appalachian Commission money, not Federal money, and may, therefore, in many instances be used as matching funds against other Federal moneys. By a formula which has been developed by the Public Health Service, it has been estimated that as much as 50 to 60 million dollars of Federal funds eventually will be poured into the development of this Program, with possibly more to follow.

Not an 'Easy Gift or Hand-Out'

Don't, for a minute, however, misunderstand me. This Program is not an easy gift or a giant hand-out. While the 202 funds will construct facilities on a 80-20 matching basis and will operate a project and absorb 100 per cent of the loss for the first two years and 50 per cent for the next three, the Commission must be given assurances that some responsible agency or institution will be able to carry on the Program at the end of the five-year period. Furthermore, it is a certainty that local money will be required in order to develop most aspects of the Program. Moreover, there is keen competition for this money from other areas in Appalachia which are developing their own programs; and without question the areas which are most aggressive and which do the most to help themselves will qualify for a major portion of this aid. In the end, probably only four or five such projects are expected to be approved by the Commission. At present there is only one project which is further developed than West Virginia's, and it involves only three counties in an affluent part of North Carolina.

Much Money, Work and Travel

Also, I would like to point out that this Program has involved hundreds of people, has required many thousands of hours in work, tens of thousands of miles in travel, and meetings so numerous that they have been lost count of. It has cost many thousands of dollars for preliminary work and study, much of which has been borne individually as well as by the State Health Department and the State Department of Commerce; and, in addition, an incredible amount of energy has been expended by those who have helped to set up the necessary organizations and to develop an acceptable Program. And yet, it is perfectly clear to all of us that we are just getting started.

This Program, as it is beginning to take form, will include improved and regionalized public health facilities and services; improved and regionalized mental health facilities and services; extended care and nursing home facilities; training and manpower programs for the training of nurses, para-medical and other supporting personnel; and new and improved medical facilities and services such as physiotherapy, intensive care units, electronic lab equipment, new emergency room facilities, etc. The Program will also include improved transportation and communication systems to make medical care available to larger groups of persons, especially to those in sparsely settled and isolated areas of the region. All of these new features are to be coordinated with existing programs, personnel, services and facilities, whether public or private, in order to provide comprehensive health care.

In conclusion, let me emphasize that in the Appalachian Regional Health Program the stakes are high; the obstacles have been almost insurmountable, but the rewards in accomplishing this Program can be enormous. These rewards are now within sight and almost within our reach. I firmly believe that from this Program a new day will dawn in Southern West Virginia in the care of the ill and afflicted. I also truly believe that we, who live in the Project Area, are on the way to a great renaissance in the enhancement of the health, in the elevation of the economy, in the improvement of the environment and in the advancement of the society of the entire region. With continued cooperation among the people, organized medicine and governmental agencies this Demonstration Health Project will be secured, and medical history will be made in the "Heart of Appalachia."

A politician is a statesman who approaches every question with an open mouth.

Adlai E. Stevenson

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Special Article

Albert Moore Reese, Ph. D. (1872-1965)

E. J. Van Liere, M. D.

SINCE 1967 marks the Centennial of both the West Virginia State Medical Association and West Virginia University, it is fitting to present a biographic sketch of an outstanding early teacher and a widely known and much respected man. Many physicians who took their premedical work at West Virginia University before 1946 knew Dr. Albert Moore Reese, Professor of Zoology. He served in the Department of Biology for 43 years and was its Chairman for 36 years.

It probably is not generally known, however, that when he first came to the University in 1903 he was also listed in the University catalog as a member of the Medical School faculty, and was so listed until 1911. The subjects he taught medical students were embryology and neurology. Despite the fact that he actually was a member of the faculty of College of Arts and Sciences, and his principal duty was teaching zoology, he played an important role in the early development of the Medical School.

Albert Reese was born in Lake Roland, Maryland, on April 1, 1872. He obtained two degrees from Johns Hopkins University, the B.A. in 1892, at the age of 20, and the Ph.D. (zoology) in 1900. After obtaining his B.A. degree he taught in a high school in Maryland for a number of years; he remained a teacher all his life. A detailed account of his early teaching experience will not be given. It is sufficient to say that he taught biology in a number of eastern institutions, including Allegheny College and Syracuse University.

Doctor Reese came to West Virginia University in 1903 in the Department of Biology as an Associate Professor of Zoology. When he arrived, the chairman of the department was John Black Johnston, Ph.D., a distinguished biologist, who later became an outstanding scientist and an educational administrator at the University of Minnesota. Doctor Johnston left in 1907 and Doctor Reese was made Chairman of the Department of Biology, a position he held until 1946, at which time he was made Emeritus Professor. He was then in his 74th year. At that time West Virginia University did not have a mandatory age of retirement such as it now has, or if it did, the rule was not enforced.

Submitted to the Publication Committee, June 2, 1967.

The Author

- **E. J. Van Liere, M. D., Dean Emeritus, West Virginia University School of Medicine, Morgantown.**

Rattlesnake Meat for Students

Doctor Reese became a well-known and distinguished zoologist. He was a splendid teacher and well liked and respected by his students. He had a dignity and quiet charm, and a good sense of humor which everyone appreciated. Although a kind and mild-mannered man, he never hesitated to stand up for what he thought was right. He was not always a conformist. On one occasion he served rattlesnake meat to a group of students. The newspapers of the land gave this wide publicity. The thought of eating rattlesnakes was, of course, repugnant to many people. Doctor Reese took all this in his stride. As a matter of fact, rattlesnake meat may now be purchased in the open market. It tastes much like the white meat of chicken, and some gourmets prefer it to chicken. The author is not one of them.

Despite his heavy teaching load, his administrative duties as chairman of a large department, his many committee assignments, and his community interests, he still found time to do research. This devotion to creative work can well serve as an example to young scientists, especially those who complain that they cannot find time for research. His main field of interest dealt with the anatomy, embryology and habits of cold-blooded vertebrates, especially alligators. He became a well-known student of alligators and his close friends jocosely referred to him as "Alligator Reese." As might be expected, he

was frequently plagued by people asking him the difference between the alligator and the crocodile. Indeed, the author shortly after he met Doctor Reese was guilty of asking him this question. Doctor Reese, always a gentleman, gave a satisfactory explanation, but through the mist of years the author unfortunately does not remember just what he was told. There is, of course, a difference, although the matter is somewhat complicated by the fact that the alligator belongs to the crocodile family.

World-Wide Traveler

Like many zoologists Doctor Reese traveled widely, and took part in scientific expeditions: A Smithsonian Institute Expedition to The Orient in 1913, and a Carnegie Institute Expedition to South America in 1919. He undoubtedly was a valuable man on these expeditions, for he was always agreeable, industrious, keenly alert, enthusiastic and appeared always to be in good health. These qualities are priceless as any one who has been on field trips or on expeditions knows.

Although short in stature and frail in appearance, he was capable of enduring a great deal of physical hardship. The author can attest to this fact from personal experience, since he had occasion to take one or two field trips with him in the Appalachian Mountains. When these trips were taken, Doctor Reese was much older than any other member of the group, but it was he who set the pace, especially when climbing steep grades. The rest of us had a difficult job trying to keep up with him. The matter can be summed up by stating that he was "tough" physically.

The author remembers one occasion when Doctor Reese slipped as he stepped out of an old Ford automobile, falling prone on a concrete pavement and actually rolling over a time or two. But this did not faze him, for he jumped up before any of us could help him, and started walking as if nothing had happened. This made a marked impression on the author who at that time was a rather young man, for he was certain that Doctor Reese had seriously injured himself. He was very active physically and walked regularly every day up to the time he was 90 years or older.

Active in Scientific Societies

Doctor Reese was a member of many scientific societies, among them were Sigma Xi, American Society of Naturalists, American Society of Zoologists, and the American Association for the Advancement of Science. He also took a keen interest in local and state societies; for example, one year he served as President of the West Virginia Academy of Science. Doctor Reese was a scholarly person and the author of many scientific papers. He wrote clearly and well. After he returned from the Smithsonian Expedition he authored an 80-page monograph, "Wanderings in The Orient"* which is written in an informative and pleasing style.

Doctor Reese took part in community affairs and was quite active in several of them; for many years he served as treasurer of the local chapter of the American Red Cross. Owing to his participation in civic affairs he became well known to many citizens not only in Morgantown, but throughout Monongalia County, and, indeed, was a much respected and highly regarded man. He died on December 30, 1965 at the age of 93; he was buried in a Morgantown cemetery.

In summary, Doctor Reese was a distinguished zoologist, a scholarly individual, and a dedicated teacher. Although a member of the College of Arts and Sciences faculty, he taught medical students embryology and neurology for eight years, shortly after the turn of the century. Throughout his long tenure at the University he taught many premedical students who remember him well and most pleasantly. Because of his high scholastic standards, his integrity and his loyalty to his students and to the University, he had a most salutary influence on the development of the Medical School. Doctor Reese would have graced the faculty of any institution.

*A. M. Reese, "Wandering in the Orient," with sixty-six illustrations from photographs. Open Court Publishing Company, Chicago, 1919.

Always imitate the behavior of the winners when you lose.

George Meredith

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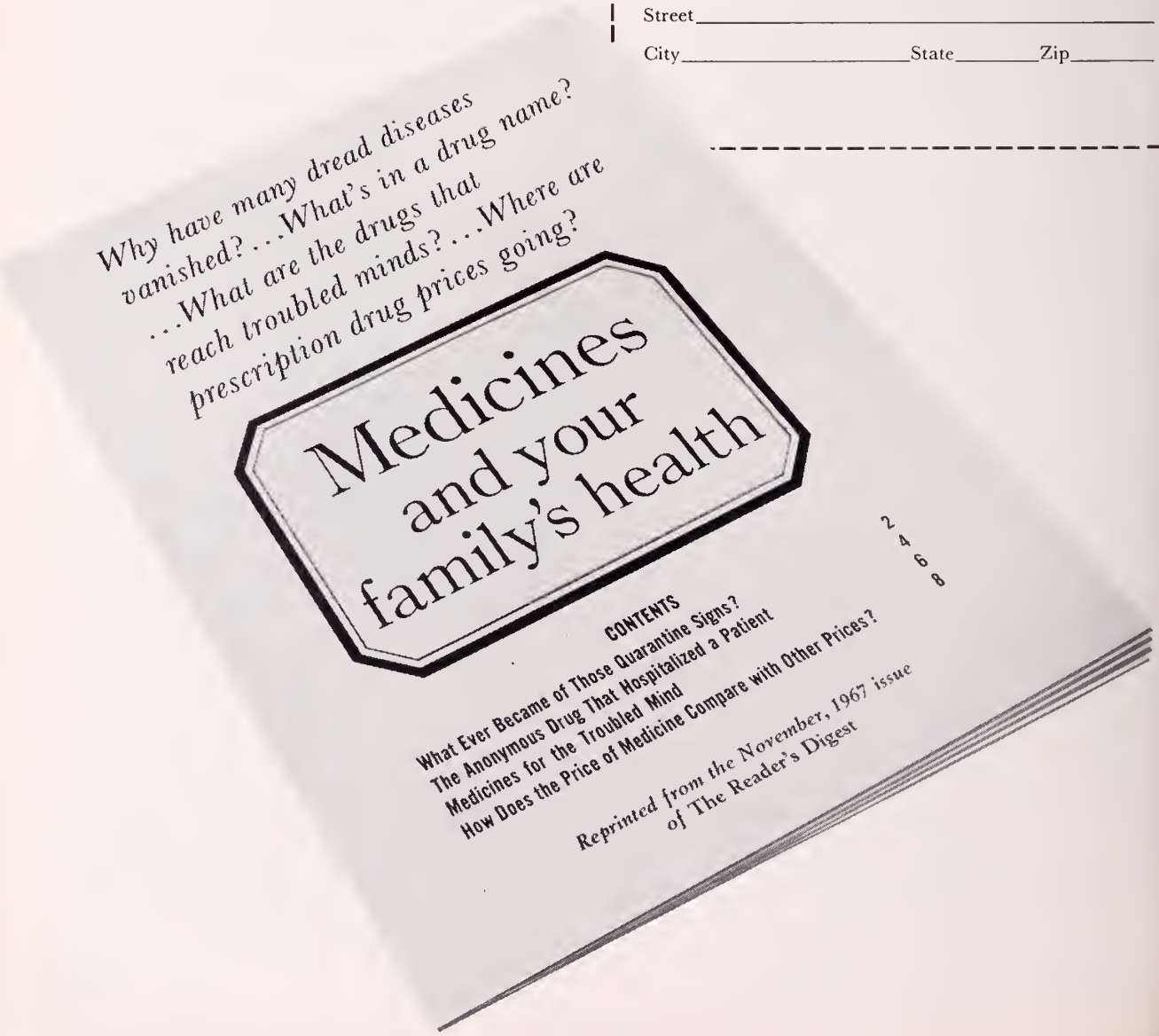

THE WEST VIRGINIA STATE MEDICAL ASSOCIATION

Announces a

Postgraduate Course in

"THE MANAGEMENT OF THE SEVERAL ARTHRIDITES"

at

Cabell-Huntington Hospital

1340 Sixteenth Street
Huntington, W. Va.

Saturday, December 16, 1967

Course Outline: 8:30 A.M.-12 N.—Etiology, Definitions and Treatment; Values and Disadvantages of the Multidiscipline Approach to the Treatment and Rehabilitation of the Arthritic; the Rheumatic Examination.

12 N.-1 P.M.—Luncheon in the hospital cafeteria.

1 P.M.-5 P.M.—Live Case Presentations; Physiotherapy and Orthopedic Techniques; Rest and Emotional Therapy; Anti-inflammatory Agents; Antimalarials and Gold; and Steroids, Analgesics, Relaxants, Uricosurics, etc.

Faculty: Daniel Hamaty, M. D., Charleston; Evelyn Hess, M. D., Cincinnati; George R. Callender, Jr., M. D., Charleston; Thomas Dotson, M. D., Morgantown; D. Sheffer Clark, M. D., Huntington, Albert C. Esposito, M. D., Huntington; Thomas F. Scott, M. D., Huntington; and Richard Moran, R.P.T., Charleston.

Registration Fee: $10.00 (includes lunch)

Maximum Registration: 40

AAGP Credit: 5 Hours

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Checks should be made payable to "West Virginia State Medical Association."

Please register me in the course on "The Management of the Several Arthridites" at Cabell-Huntington Hospital in Huntington on December 16, 1967. My registration fee of $10.00 is (is not) enclosed.

Name (please print) _____ *Specialty* _____

Address _____ *City* _____

A message from . . .

The President

MERRY CHRISTMAS

We are now entering the Christmas Season with its theme of "Peace on Earth, Good Will Toward Men." As your President, I want to wish every physician in the West Virginia State Medical Association and his family and the entire membership of the Woman's Auxiliary a very Merry Christmas and a Happy New Year.

Now, although it is the season to be jolly, I hope that every member of our two organizations will find time in the midst of merry-making to reflect upon our past accomplishments and to plan our future paths. There is much to be done in the coming years. We are in the midst of great changes of social, political and economic importance to the medical profession. It will require all of our wisdom and courage to meet these challenges and to guide our state and country in the direction in which it should go in the field of medicine. I ask for the support and advice of everyone in our attempt to control the future of medical practice.

With these objectives in mind, I pray that the New Year will bring great benefits and new direction to us all. I pray that we shall have serene, happy and thoughtful minds containing the wisdom, knowledge and ability to conduct ourselves always as top-notch physicians and teachers throughout the State and nation. I pray that the coming year will find us capable of making progress through medicine toward the brotherhood of man with friendship and love toward all men, but with the fortitude and courage to maintain our convictions as to what is right for medicine.

So to the physicians of this State I say, have a lovely Christmas and prepare for a joyful and prosperous New Year.

Richard V. Lynch, Jr., M.D.

Richard V. Lynch, Jr., M. D., *President*

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

THE DRUG PROBLEM AMONG YOUNG PEOPLE

Elsewhere in this issue of *The Journal* appears an article, "The Drug Problem Among Young People," by Dana L. Farnsworth, M. D., Director, University Health Service, and Henry K. Oliver Professor of Hygiene, Harvard University. This timely article points out the danger of certain drugs, especially lysergic acid diethylamide (LSD), and cannabis (marijuana). The article emphasizes the potential danger of the use of these drugs, especially in young people. As Director of the Health Service of a large University and a nationally known psychiatrist, Farnsworth writes authoritatively and documents his own observations as well as those made by others.

There is definite evidence that LSD is a potentially dangerous drug, and that its use in some individuals may cause irreparable damage. This alone should discourage its unrestricted use. Among other things it impairs the subjects' ability to make realistic judgments, and may produce a condition comparable in some respects to those found in certain psychoses. It is incredible that any individual would advocate the use of any preparation which would impair realistic judgment. The drug may be of some use in the experimental psychological laboratory where it may be administered under close supervision. But certainly the drug should not be used by college students, or for that matter, by any other citizen; its use should always be supervised by experts in the field.

The effect of marijuana is somewhat controversial. There are some who believe that it is a relatively harmless drug, and those who take it have distinct personality defects, and it is these defects, rather than the drug, which cause difficulty. On the other hand, some observers, and Farnsworth quotes Keeler, believe that marijuana users may show untoward symptoms, such as pain, fear, depersonalization, disorientation, and paranoid reactions. Farnsworth believes that the use of marijuana does entail risk and gives several case histories to support his views. In fact, even if there is some difference of opinion of the effects of marijuana, the least that can be said is that its use should not be advised.

Space does not permit, or is it in order in this short essay, to give in detail the various points Farnsworth brings out concerning the reasons students take dangerous drugs or what can be done to help these unfortunate young people. Suffice it to say that all responsible people in all walks of life should be made aware

of the problem and do what they can to prevent the spread of the use of the drugs, such as LSD and marijuana. The problem is an important and pressing one, and should receive the attention of both state and federal agencies. The American Medical Association through its Council on Mental Health and Committee on Alcoholism and Drug-Dependence in a recent issue of its Journal[1] calls attention to the hallucinogenic drugs and emphasizes the importance of the problem.

The physician is certainly on firm ground when he strongly advises his patients to avoid the use of either LSD or marijuana. So far as it is known neither drug offers effective treatment for any disorder. It is probably true that some individuals are less susceptible to these drugs than are others, but it is almost impossible to predict who these persons are.

It is noteworthy that the staff of the Student Health Service of West Virginia University thus far has not had to deal with users of either LSD or marijuana. This is most gratifying indeed, and it is to be hoped that students on the campus will continue to avoid the use of these potentially dangerous drugs.

1. J.A.M.A. Vol. 202, No. 1, Oct. 2, 1967 (p. 47)

Fewer New Drugs Introduced

The United States established a new pharmaceutical record in 1966—fewer new medicines were introduced in 1966 then in any of the previous 18 years for which accurate statistics are available.

Only 80 prescription drug products were introduced last year. This is down from 112 products new to the market in 1965. In the past 10 years, the number of new medicines approved by the FDA for marketing has declined 80 per cent.

The term "new drug products" includes single chemical agents, duplicates of existing products such as meprobamate which is put out by several companies, combinations of existing products and new dosage forms.

As an indication of progress, the number of new single chemical agents is most significant. This important class shows the sharpest decline, down to 12 in 1966 after a high of 63 in 1959.

As compared with the four large nations of western Europe, the U.S. was in fifth place last year in the introduction of new single agents. Germany, France, Italy, Great Britain and the United States scored respectively 42, 34, 21, 20 and 12. One third of all these drugs were developed by American scientists.

The Drug Information Service of Paul de Haen, Inc., reports on the above statistics and emphasizes that during 1966, the American drug industry marketed seven new single chemical agents in Europe, none of which was available to physicians in the United States in 1966, although two of them were approved in January of this year.

The pharmaceutical decline was not limited to products but included pharmaceutical firms which introduced new products. In 1957, 127 American companies had new medicines approved for the market; in 1966 there were only 66. de Haen comments that the increased cost of research and the longer and more expensive clinical research involved may be eliminating the smaller drug houses as researchers.—*The Journal of the Indiana State Medical Association.*

Public Health and Pigeons

Pigeons are not man's best friend. They are creating public health problems in addition to being messy and a nuisance. Those who doubt this should walk under Michigan Avenue near the Sheraton-Chicago Hotel or along the sidewalk bordering the city's library. Pigeon-lovers and feeders are a vocal group, but our officials now have enough ammunition to combat the pleas of our bleeding hearts.

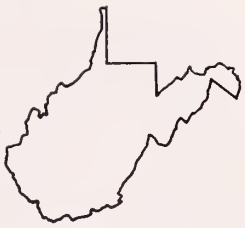
A New York mycologist found that the fungi responsible for cryptococcal meningitis came from pigeon droppings and not from the soil. He was able to isolate the organisms from 50 per cent of samples of pigeon excreta whereas they were found in less than one per cent of soil samples. This serious disease responds to Amphotericin-B provided the drug is used early. Although the death rate has been cut in half, about 30 per cent of infected individuals still die.

Some people are allergic to the dandruff, feathers, and excreta of pigeons. The majority are subject to atopic diseases and develop asthma when exposed to the offending agents. Bird fancier's lung is different in that it develops in nonatopic patients. After inhalation of antigens from avian excreta, an allergic alveolitis develops through the mediation of specific precipitins. In this respect, it is somewhat similar to hypersensitivity reactions that follow the inhalation of organic dusts responsible for farmer's lung and bagassosis.

The symptoms of bird fancier's lung develop insidiously or fairly abruptly following exposure. Rapid breathing, cough, malaise, and fever ensue. Scattered crepitations are heard but there is no evidence of airway obstruction. Chest x-ray shows slight mottling that is out of proportion to the severity of the symptoms.

The findings subside on removal of the stimulus but repeated or prolonged exposure may lead to diffuse reticulation and fibrosis. The corticosteroid drugs are most helpful in resolving the exudate and limiting pulmonary damage. Diagnosis is simple, provided the possibility is considered. Treatment consists of removal of the cause.—T. R. Van Dellen, M. D., in *Illinois Medical Journal.*

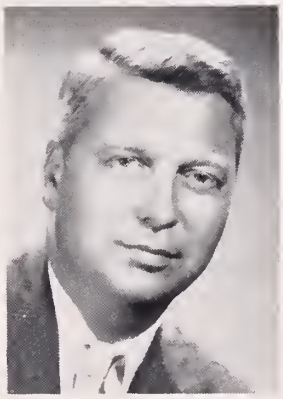
GENERAL NEWS



Education Committee Lists Second PG Course

The second postgraduate medical education course to be sponsored by the Committee on Medical Education and Hospitals of the West Virginia State Medical Association will be held at Cabell-Huntington Hospital in Huntington on Saturday, December 16.

Daniel Hamaty, M. D.



Geo. R. Callender, Jr., M. D.

Dr. Daniel Hamaty of Charleston, a rheumatologist and a member of the Committee, is in charge of the course, which is entitled "The Management of the Several Arthridites." Members of the American Academy of General Practice may receive five hours of credit for attending the course.

In addition to Doctor Hamaty, the faculty will consist of Dr. Evelyn Hess, Director of Immunology at the University of Cincinnati College of Medicine; Dr. Thomas Dotson, Chief Resident in Medicine at the West Virginia University School of Medicine; Dr. D. Sheffer Clark of Huntington, internist; Drs. Thomas F. Scott of Huntington and George R. Callender, Jr., of Charleston, orthopedic surgeons; Dr. Albert Esposito of Huntington, ophthalmologist; Mr. Richard Moran, R.P.T., Chief Physical Therapist at Charleston Memorial Hospital; and others.

Doctor Hamaty said the course would be oriented around the presentation of general facts and skills involved in the general care and rehabilitation of arthritics. There will be lectures, medical motion pictures and presentation of live cases.

One feature of the program will be a discussion of the multidiscipline approach to the treatment of arthritis, including the services of the rheumatologist, orthopedist, physiotherapist and nurse.

Other parts of the program will deal with etiology, treatment and the rheumatic examination; physiotherapy and orthopedic techniques; rest and emotional therapy; anti-inflammatory agents; antimalarials and gold; steroids, analgesics, relaxants, uricosurics, etc.

Several months ago, the Committee on Medical Education and Hospitals embraced the philosophy that any postgraduate courses it would sponsor should be conducted in a hospital setting and should feature the use of local physicians as teachers and the use of live patient demonstrations.

The first such course, "Cardiac Auscultation Review," was given at Thomas Hospital in South Charleston in September. Results of a questionnaire distributed to participants indicated that program was well received.

Registration will begin at 8 A. M., and the course will be over by 5 P. M. The registration fee will be $10, and there will be no additional charge for lunch at the hospital.

A registration form for the course appears elsewhere in this issue of *The Journal.*

Although the course is intended primarily for physicians in the Huntington area, all members of the West Virginia State Medical Association are invited to attend.

Symposium on Muscular Exercise Available to Physicians

A symposium on "The Physiology of Muscular Exercise," which summarizes present knowledge in the field, has been published by the American Heart Association as Number 15 in its Monograph Series.

The 230-page volume covers central and peripheral circulatory factors, phenomena in the muscle cell, respiratory factors and control mechanisms. A final section concerns the general aspects of adaptation to exercise in man. Dr. Carleton B. Chapman, Dean of the Dartmouth Medical School, edited the symposium's proceedings.

Physicians, medical schools and hospitals may obtain the publication at $3.00 a copy from the West Virginia Heart Association, 211 35th Street, S. E., Charleston, West Virginia 25304.

Postgraduate Course in Ophthalmology

The Cleveland Clinic Educational Foundation will sponsor a Postgraduate Course in Ophthalmology in Cleveland, December 6 and 7.

Information may be obtained by contacting the Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

Medicare Not Available Outside U.S.A.

Americans traveling or living abroad have been cautioned not to expect Medicare to pay their out-of-country medical bills.

According to a Health Insurance Institute review of Medicare provisions, an over-65 citizen requiring medical attention outside the United States is personally responsible for paying for it. This includes tens-of-thousands of aged persons under Social Security now living abroad.

That's the law, says the Institute, with one exception. Should an elderly American have to be rushed to a Canadian or Mexican border hospital, provided the emergency occurred in the United States, he would still be entitled to Medicare benefits.

Many Americans are avoiding this problem by purchasing private insurance to supplement their Medicare coverage or through special trip policies which cover foreign medical costs.

An Institute survey conducted at the outset of the Medicare program showed that at least 70 companies offered over 100 supplementary plans, including many that covered foreign travel.

The majority of these plans are designated to either provide benefits for medical expenses not covered by Medicare or to provide a cash benefit amount which can be used to pay for expenses (medical and otherwise) incidental to the illness or injury.

The only areas outside the United States where Medicare remains in effect, says the Institute, are Puerto Rico, Guam, the Virgin Islands and American Samoa.

Beckley Surgeon Is Honored By Alma Mater

Dr. Clifford A. Stevenson of Beckley, an orthopedic surgeon, has been elected to the Bowling Green State University Athletic Hall of Fame.

Doctor Stevenson was among six former Bowling Green athletes to be admitted to the Hall this year. He was an outstanding center on the 1928-31 football teams at the university.

He captained the team as a senior and won the most valuable player award. He also earned letters in basketball and track.

Doctor Stevenson later earned his M. D. degree at Emory University and served as a Navy Surgeon for 23 years, retiring with the rank of Captain in 1963.

Dr. Heckman Named To Committee

Dr. James A. Heckman of Huntington has been appointed to the Committee on Injuries of the American Academy of Orthopaedic Surgeons.

Doctor Heckman will serve on the Subcommittee on Emergency Care.

MLB Licenses 47 Physicians To Practice in State

The following seven physicians were licensed by reciprocity to practice medicine in the State of West Virginia at a meeting of the Medical Licensing Board which was held in Charleston on April 10, 1967:

Garrett, Genevieve M., White Sulphur Springs
Gyorgy, Tilbert R. M., Huntington
Messinger, Karl Henry, Parkersburg
Nettles, George Stueard, Elkins
Schram, Duane Arthur, Williamson
Traubert, John William, Wellsburg
Wiersma, Silas Clarence, Institute

The Board also met on July 17-19 and licensed the following 15 physicians by reciprocity:

Anton, Charles Joseph, Jr., Huntington
Artz, Steven Albert, Charleston
Baker, Robert Francis, Fairmont
Bazo, Albert James, Moundsville
Beckett, Kenneth Larry, Seth
Bernie, William Allen, Morgantown
Cottle, Aaron DePue, Spencer
Dunworth, Robert Lawrence, Huntington
Linkous, Clayton Eugene, Jr., Bethesda, Maryland
Maiolo, Joseph Anthony, Beckley
Mathias, Phillip Benjamin, Morgantown
Salisbury, Robert Samuel, Fairmont
Stewart, William Crawford, II, Morgantown
Stupar, Ronald Kent, Wheeling
Yarington, Charles Thomas, Jr., Morgantown

At the same meeting, the following 25 physicians were licensed by direct examination to practice medicine in the State of West Virginia:

Asaad, Blanche Labib, Moundsville
Asaad, Ezzat Naguib, Moundsville
Borbely, Leslie J., Spencer
Brantly, James Monroe, Indianapolis, Indiana
Brooks, Arlo Paul, Jr., Fairchild AFB, Washington
Carney, James Francis, Clarksburg
Christian, William Erman, Jr., Morgantown
Cosmides, Maritsa Penelope, Akron, Ohio
de Lemos, Gaston Pereira, Huntington
Eschenmann, Ethel Louise, Morgantown
Gregg, Patricia McKay, Morgantown
Haislip, Charles Edward, Grafton
Henson, Samuel Lee, Charleston
Klinestiver, Donald Gerould, Huntington
Leroy, Charles Anthony, Tennafly, N. J.
Majestro, Tony Colerio, Charleston
Misak, Steve Joseph, Bluefield
Rodriguez, Fidel, Grantsville
Sabo, Sandra Kovach, Morgantown
Schwab, Larry Tidd, Kingwood
Sprogis, Milda, Barboursville
Vinall, Sidney Alex, Denver, Colorado
Wanger, Helge Alexander, Morgantown
Ward, Arthur Nelson, Fairmont
Woods, Sharon Roberta, Mullens

The next meeting of the MLB will be held in Charleston at The Capitol, January 8-10, 1968, for the licensing of physicians to practice medicine in the State of West Virginia both by direct examination and reciprocity.

New Association Members

Dr. L. B. Craycraft, 1409 Chestnut Street, Kenova (Cabell). Doctor Craycraft, a native of Kenova, was graduated from the West Virginia University School of Pharmacy. He received his M. D. degree in 1963 from the WVU School of Medicine and served his internship at Mercy Hospital in Springfield, Ohio, 1963-64. He is engaged in general practice.

★ ★ ★ ★

Dr. Norman Franklin, Wheeling Hospital, Wheeling (Ohio). Doctor Franklin, a native of Wheeling, was graduated from Bethany College and attended the two-year WVU School of Medicine. He received his M. D. degree in 1957 from the Medical College of Virginia. He interned at Montefiore Hospital in Pittsburgh, 1957-58, and served residencies at that hospital and at the University of Washington Hospital in Seattle, 1961-64. He served as a Captain in the Medical Corps of the United States Air Force, 1959-61. His specialty is pathology.

★ ★ ★ ★

Dr. James A. Lilly, Eastern Heights Shopping Center, Huntington (Cabell). Doctor Lilly, a native of Mason County, was graduated from Marshall University and received his M. D. degree in 1964 from the West Virginia University School of Medicine. He interned and served a residency at Cabell-Huntington Hospital, 1964-66. He served with the United States Navy, 1948-52, and he is engaged in general practice.

★ ★ ★ ★

Dr. Robert E. Roberts, Grant Memorial Hospital, Petersburg (Potomac Valley). Doctor Roberts, a native of Toledo, Ohio, was graduated from the University of Toledo in 1949, and received his M. D. degree in 1953 from the University of Indiana School of Medicine. He interned at the University of Indiana Hospital, 1953-54, and served residencies at Beckley Hospital, 1954-55, and Maumee Valley Hospital in Toledo, 1957-61. He served with the Medical Corps of the United States Army, 1955-59, and his specialty is general surgery.

★ ★ ★ ★

Dr. Gene D. Sherrill, 1206 Quarrier Street, Charleston (Kanawha). Doctor Sherrill, a native of Pittsburgh, Pennsylvania, was graduated from Ohio University in 1939 and received his M. D. degree in 1943 from the State University at Buffalo. He interned at Youngstown Hospital, 1943-44, and served a residency at the Cleveland Clinic, 1951-54. He served with the United States Army and his specialty is dermatology.

★ ★ ★ ★

Dr. Joseph G. Vazquez, High Street, Grantsville (Parkersburg Academy). Doctor Vazquez, a native of New York City, was graduated from the University of Puerto Rico in 1950 and received his M. D. degree in 1954 from the School of Medicine of Puerto Rico. He interned at Hospital Santo Asilo de Damas, Ponce, Puerto Rico, 1954-55. He served as a Captain in the Medical Corps of the United States Air Force, 1956-58, and he previously was located at Man. He is engaged in general practice.

Looking Back 10 Years...

This picture of three Past Presidents of the West Virginia State Medical Association was taken at a meeting sponsored by the Association in the autumn of 1957 in Charleston. From left to right are: Drs. L. J. Pace of Princeton; Athey R. Lutz of Parkersburg; and J. C. Huffman of Buckhannon. At time picture was taken, Doctor Lutz was Immediate Past President, and Drs. Huffman and Pace were to serve in the Association's highest office a few years later.

W. Va. Nurses Association Elects Miss Coyne

Miss Cecilia Coyne of Bridgeport, Ohio, was elected President of the West Virginia Nurses Association, Inc., during the group's annual meeting, October 18-20.

She succeeds Mrs. Josephine Fultz of Clarksburg, who will serve on the Board for the coming year.

Other new officers are: Miss Nancy K. Martin of Moundsville, First Vice President; Mrs. Jean Capp of Morgantown, Second Vice President; Miss Audrey Windemuth of Morgantown, Secretary; and Miss Dorothea L. Fee of Charleston, Treasurer.

Serving with Mrs. Fultz on the Board will be: Sister Susan Novak of Clarksburg; Mrs. Ardenia Tully of South Charleston; and Mrs. Bernice Vance of Clarksburg.

Ophthalmology Group Re-Elects West Virginians

Two West Virginia physicians were re-elected to their executive positions during the Annual Meeting of the American Association of Ophthalmology in Chicago in October.

Re-elected Secretary was Dr. Albert C. Esposito of Huntington, a Past President of the West Virginia State Medical Association. Dr. Ralph W. Ryan of Morgantown will serve as Treasurer for another year.

Food Poisoning Is Discussed By Doctor Dyer

Every day all of us consume many food products that have been prepared, packaged, stored and marketed under excellent conditions with regular inspection of raw materials and preparation facilities by industrial and government inspectors. Many of us assume that every foodstuff has had to pass routine inspection and minimum standards before it can be marketed. Yet, even today, we frequently ingest foods prepared from poor materials with inadequate facilities for quality control.

The subject of food poisoning was the concern of State Health Director N. H. Dyer in a recent issue of the "State of the State's Health."

The very wide distribution of foodstuffs in interstate commerce magnifies the difficulties in assuring the public of safe consumer goods, he said. All health workers can contribute to further control by being continuously on the alert for common-source disease spread, and by reporting it immediately to the local health authorities. Adequate control measures to prevent further spread can be instituted only if the contaminated source can be found and eliminated.

Doctor Dyer reported that out of 181 foodborne outbreaks reported to the National Communicable Disease Center in 1966, the cause was determined for only 73.

The health official discussed the food poisoning incident which occurred at the West Virginia University-Virginia Military Institute football game last September 23.

Sunday evening, September 24, the first of over 700 WVU students to seek medical aid for a gastrointestinal upset appeared at the Medical Center Emergency Room. The predominant symptoms were nausea, vomiting, diarrhea, cramps, and fever. Many of the students were admitted to the hospital because of severe dehydration. The only common source for the vast majority of those involved was a foodstuff served at the game.

Over 400 well and ill WVU students completed a questionnaire designed to help track down the common source. Of these, 337 were at the game and of those, 185 had experienced two or more of the eight cardinal symptoms represented in the clinical illness. The survey also showed that less than half of the affected students came in for medical care, implying that 1,500 WVU students had been ill, or about 19 per cent of those at the game.

The high schools from four states that had sent groups to the game were contacted, and reported attack rates of up to 60 per cent among the student groups that had been to the game. The average attack rate was 15 per cent for all high school students at the game. If 15 per cent of all those at the game became ill, there could have been as many as 4,000 people affected by this illness. The acute symptoms of vomiting and diarrhea lasted four to 24 hours, but the residual malaise and fatigue lasted several days. There were no deaths, and the most severely affected recovered without any apparent residual effects.

Local and state health authorities organized an immediate search for the source of contamination and control measures were instituted where necessary, Doctor Dyer pointed out.

He said that epidemiologic proof of what was the carrier of the food-poisoning has been established, but the bacteriologic proof of a causative organism has not yet been completed.

Because any food supplier could be the victim of circumstance if he is supplied with a contaminated raw material, Doctor Dyer said, it behooves each and every food handler to be responsible for the safety of his product from the point of origin to the time of consumption. For the good of the community, if a product comes under scrutiny, the producer and local supplier should do everything in their power to cooperate with health officials in protecting the public from contaminated foodstuffs, he said.

Loan Fund Information Released by ACCP

The following information concerning the Resident Loan Fund of the American College of Chest Physicians was submitted to *The Journal* for publication:

The Resident Loan Fund was established by the American College of Chest Physicians to assist young physicians in taking postgraduate training in the specialty of diseases of the chest. Any qualified resident may apply for a loan by writing to the Committee on Resident Loan Fund in care of the Executive Offices of the College. All applications must be approved by the Committee before a loan can be granted.

The total amount of a loan to any individual in any one year may not exceed $1,500.00 and, except under special circumstances, the loan will be made available on the basis of $125.00 per month. No individual may borrow more than $4,500.00. All loans must be protected by life insurance, the premiums to be paid by the borrower.

Interest on the loan is charged at the rate of three per cent per annum. Neither principal nor interest on the loan need be repaid for a period of three years after the date of the first loan advance, provided the physician is continuing his postgraduate training in diseases of the chest.

Lawrence Frankel Foundation Receives $500 Gift

The Medical Advisory Committee of the Lawrence Frankel Foundation of Charleston has announced a gift of $500 from the Ciba Pharmaceutical Company of Summit, New Jersey, to aid in a study of the role of exercise in preventive cardiology.

Ciba had made an initial contribution of $1,000.

Dr. John A. B. Holt of Charleston is Chairman of the Medical Advisory Committee. Other members are Drs. William B. Rossman, Marshall J. Carper, William E. Lawton, J. Paul Aliff and Carl J. Roncaglione.

Cleveland Clinic Schedules Surgery Course

A postgraduate course entitled "The Treatment of Surgical Emergencies" will be sponsored by the Cleveland Clinic Educational Foundation in Cleveland, January 17-18.

Three guest speakers will join 25 members of the Clinic staff in presenting the program.

Registration fee is $40.

Programs and additional information may be obtained by writing to: Education Secretary, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

Lung Disease Program In Charleston

Registrations are being accepted for a Symposium on Chronic Obstructive Disease of the Lung, which will be held at Holiday Inn No. 1 in Charleston on December 10.

The program is sponsored by West Virginia University and the West Virginia Thoracic Society.

Moderator will be Dr. R. H. Nestmann of Charleston, and speakers will include the following members of the faculty of the WVU School of Medicine:

Dr. William Keith C. Morgan, Associate Professor of Medicine; Dr. N. Leroy Lapp, Instructor in Medicine; Dr. Benjamin M. Stout, Assistant Professor of Medicine; Dr. David Russakoff, Instructor in Medicine; and Dr. Charles E. Andrews, Professor of Medicine and Acting Director of the Medical Center.

Information may be obtained by writing to Mr. Thomas A. Deveny, Jr., Executive Director, West Virginia Tuberculosis and Health Association, P. O. Box 341, Charleston, West Virginia 25322.

Dr. John C. Krantz (left), Professor Emeritus of Pharmacology at the University of Maryland School of Medicine, was the after-dinner speaker for the Friday night dinner at the Annual Potomac-Shenandoah Valley Postgraduate Institute, which was held in Martinsburg, October 27-29. Doctor Krantz's address was entitled "On Having An Educated Heart." Others in picture are Mrs. Krantz; Dr. Richard V. Lynch, Jr., of Clarksburg, President of the West Virginia State Medical Association; and Dr. Halvard Wanger of Shepherdstown, Executive Director of the Institute.

Meeting on 'Psychiatry for the GP'

A program on "Psychiatry for the General Practitioner," sponsored by the Portsmouth Receiving Hospital, will be held at the Holiday Inn in Portsmouth, Ohio, on Thursday, December 14. The program will begin at 10 A.M. and end at 4 P.M. Physicians attending the meeting will be the guests of the Hospital at a luncheon.

West Virginia physicians are invited to attend and additional details may be obtained by writing Dr. Sheldon Rogers, Clinical Director, Portsmouth Receiving Hospital, 25th and Elmwood Drive, Portsmouth, Ohio 45662.

Roundtable discussions of various medical and surgical topics were special features of the Potomac-Shenandoah Valley Postgraduate Institute in Martinsburg in October. A partial view of one roundtable is shown in picture at left. Pictured from left to right are Dr. E. Andrew Zepp of Martinsburg; Dr. Robert J. Johnson of Philadelphia, a guest speaker; and Dr. John E. Echols of Richwood. Dr. Leo J. Dunn of Richmond, Virginia, (center in right picture) chats with two young physicians attending the Postgraduate Institute. At left is Dr. Alexander H. Wanger, a resident in obstetrics and gynecology at the WVU Medical Center and son of Dr. Halvard Wanger, Director of the Institute. At right is young Doctor Wanger's wife, Dr. Nancy Wanger, an intern at the Medical Center. Doctor Dunn, Professor and Chairman of the Department of Obstetrics and Gynecology at the Medical College of Virginia, was a guest speaker at the Institute.

The 1968 Program Committee held its first planning session at The Charleston House in Charleston on Sunday, October 22. Seated are Drs. Richard V. Lynch, Jr., of Clarksburg, President of the West Virginia State Medical Association; and Dr. George F. Evans, also of Clarksburg, Chairman of the Program Committee. Standing: Dr. Charles E. Andrews of Morgantown; Dr. A. J. Villani of Welch; and Dr. Kenneth G. MacDonald of Charleston. The Committee is planning the scientific program for the Association's 101st Annual Meeting at The Greenbrier in White Sulphur Springs next August.

Dr. Walter H. Gerwig Accepts Michigan Post

Dr. Walter H. Gerwig, Jr., Chief of Staff of the Veterans Administration Hospital in Clarksburg, has been appointed Chief of the Surgical Service at the VA Hospital at Allen Park, Detroit, Michigan.

The appointment was effective on November 1. Doctor Gerwig also will serve as Professor of Surgery at Wayne State University School of Medicine in Detroit.

Doctor Gerwig is a member of the West Virginia State Medical Association, a Diplomate of the American Board of Surgery, and a Fellow of the American College of Surgeons.

Doctor Scherr Presents Papers

Dr. Merle S. Scherr of Charleston will be among the guest speakers at a postgraduate symposium on arthritis and allergy which will be sponsored by the Greater Boston Medical Society and Phi Delta Epsilon at the Sheraton-Boston Hotel in Boston on December 3.

Doctor Scherr, who is Chief of the Allergy Clinic at Charleston Memorial Hospital, will present a paper on "Modern Rehabilitation of the Asthmatic Child."

Doctor Scherr also was among the speakers at the 6th International Congress of Allergology which was held in Montreal, Canada, November 5-11. He discussed the establishment of Broncho Junction, a rehabilitation summer camp for asthmatic children in Putnam County.

ACP Schedule of Courses For 1967-68

The American College of Physicians' postgraduate course schedule for the remainder of 1967-68 is as follows:

Dec. 4-8—"Radio-Isotopes and Nuclear Radiations in Medicine," Berkeley, California.

Dec. 11-15—"Advances in Medical Oncology," Houston, Texas.

Jan. 15-19—"Neurology and the Internist," Miami Beach.

Feb. 5-9—"Psychiatry and the Internist," Los Angeles.

Feb. 19-23—"Intensive Care Units," Cincinnati.

Feb. 28-Mar. 2—"Hypertensive Cardiovascular Diseases: Mechanisms and Treatment," Montreal.

Mar. 14-16—"The Clinical Selection of Patients for Cardiac Surgery," Rochester, Minnesota.

Mar. 18-22—"Psychiatry and the Internist," Albany, New York.

Mar. 27-30—"Current Concepts in Physiology of Respiration, Circulation and Electrolyte Metabolism," Boston.

Apr. 22-26—"Clinical Endocrinology — Recent Advances in Diagnosis and Treatment," Rochester, Minnesota.

May 12-15—"Frontiers in Gastroenterology," Philadelphia.

May 20-24—"The Prevention and Early Detection of Disease in Clinical Practice," Philadelphia.

May 27-31—"Auscultation of the Heart," Philadelphia.

June 10-14—"Basic Principles in Internal Medicine—1968," Iowa City, Iowa.

June 17-19—"Intensive Care Units," Denver.

June 19-21—"Infectious Diseases—Mechanisms and Manifestations," Baltimore.

Tuition fees include $60 for each course for ACP members and $100 for nonmembers.

Additional information may be obtained by contacting Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania.

PG Course in Cardiology In Phoenix

A postgraduate course entitled "Current Concepts in Cardiology" will be offered at Phoenix, Arizona, January 10-12, 1968.

Sponsors are the Institute for Cardiovascular Diseases of Good Samaritan Hospital and the American College of Cardiology. The sessions will be held at Del Webb's Towne House.

This is an official program of the American College of Cardiology.

Additional information about the program may be obtained by writing to Mr. William D. Nelligan, Executive Director, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014.

101ST ANNUAL MEETING

of the

West Virginia State Medical Association

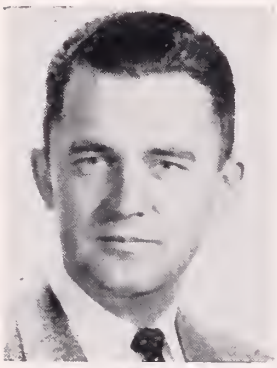
The Greenbrier

AUGUST 22 - 24, 1968

PLAN NOW TO ATTEND

Dr. Alvin Watne Is Elected Cancer Division Head

Dr. Alvin L. Watne of Morgantown, Professor of Surgery at the West Virginia University School of Medicine, has been elected President of the West Virginia Division of the American Cancer Society.



Alvin L. Watne, M. D.

Doctor Watne's elevation to the presidency came at a meeting of the Division's Board of Directors at Oglebay Park in Wheeling on October 29.

Mr. Norris Kantor, a Bluefield attorney, was elected Vice President of the Division. Re-elected were Mrs. David N. Thomas of Weirton, Chairman of the Executive Committee of the Board; Miss Marjorie Scott of Wheeling, Secretary; and Mr. Max W. Saunders of Charleston, Treasurer.

The Division's Board of Directors includes the following physicians:

Drs. Watne; Jack Burnett of Wheeling; Hugh H. Cook, Jr., of Elkins; L. Walter Fix of Martinsburg; David B. Thornburgh of Parkersburg; Paul E. Prillaman of Ronceverte; James P. Carey of Huntington; David B. Gray of Charleston; W. E. Copenhaver of Bluefield; E. R. Chillag of Logan; John C. Condry of Charleston; Richard A. Currie of Morgantown; John J. Mahood of Bluefield; Vernon E. Duckwall of Elkins; N. Allen Dyer of Charleston; I. Braxton Anderson of Beckley; David H. Williams of Weirton; Delbert C. Smith of Fairmont; and Bernard Zimmermann of Morgantown.

It was announced at the Board meeting that the Division had just completed its most successful year. A total of $314,868.07 was raised, according to an official audit.

Doctor Watne, a native of Illinois, attended the University of Illinois and received his M. D. degree from the University of Illinois College of Medicine in 1952. He joined the WVU School of Medicine in 1962 as Associate Professor of Surgery and Cancer Coordinator of the Medical Center. He was promoted to Professor several months ago.

His professional memberships include the Monongalia County Medical Society, the West Virginia State Medical Association, the American Medical Association, the American Cancer Society, the American Association for Cancer Research, the American College of Surgeons and the American Association for the Advancement of Science.

Since 1954, he has been the author or co-author of 64 scientific articles and book chapters.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled in the coming months.

1967

Dec. 2-7—Am. Acad. of Dermatology, Chicago.
Dec. 4-6—Sou. Surgical Assn., Hot Springs, Va.
Dec. 26-31—Am. Assn. for the Advancement of Science, New York.

1968

Jan. 17-18—Am. Rheumatism Assn., Baltimore.
Jan. 20-25—Am. Acad. of Orthopaedic Surgeons, Chicago.
Jan. 29-31—Soc. of Thoracic Sur., New Orleans.

Feb. 3-7—Am. Acad. of Allergy, Boston.
Feb. 6-10—Am. Col. of Radiology, Chicago.
Feb. 23-24—ACP Regional, Cincinnati.
Feb. 28-March 3—Am. Col. of Cardiology, San Francisco.

March 18-20—Am. Acad. of Ped., Atlanta.
March 24-29—Am. Col. of Allergists, Denver.
March 29-30—AMA Nat. Conf. on Rural Health, Seattle.
March 29-31—Am. Soc. of Int. Med., Boston.

April 1-5—ACP, Boston.
April 1-5—Gill Mem. EET Hospital Spring Congress, Roanoke, Va.
April 7-11—Am. Assn. of Neur. Surg., Chicago.
April 16-19—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 17-19—Maryland Medical, Baltimore.
April 22-24—Am. Assn. for Thoracic Surg., Pittsburgh.
April 22-25—Am. Col. of Ob. & Gyn., Chicago.
April 22-27—Am. Acad. of Neurology, Chicago.
April 25-26—Am. Hosp. Assn., Hollywood, Fla.

May 1-2—Am. Ped. Soc., Atlantic City.
May 7-8—Assn. of Am. Phys., Atlantic City.
May 12-17—Am. Psy. Assn., Boston.
May 13-16—Am. Urological Assn., Miami Beach.
May 14-17—Ohio Medical, Cincinnati.
May 19-22—Nat. TB Assn., Houston.
May 23-25—Am. Gyn. Soc., Hot Springs, Va.

June 14-15—Am. Rheumatism Assn., Seattle.
June 15—Acad. of TB Phys., San Francisco.
June 15-16—Am. Diabetes Assn., San Francisco.
June 16-20—Am. Col. of Chest Phys., San Francisco.
June 16-20—Am. Col. of Preventive Med., San Francisco.
June 16-20—AMA, San Francisco.
June 17-19—Am. Neurological Assn., Washington.
June 20-22—Am. Med. Women's Assn., San Francisco.
June 26-27—Am. Geriatrics Soc., New Orleans.

Aug. 12-15—Am. Hosp. Assn., New York.
Aug. 22-24—101st Annual Meeting, W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.

Sept. 5-7—Am. Assn. of Ob. & Gyn., Hot Springs, Va.
Sept. 13-15—W. Va. Heart Assn., Charleston.
Sept. 13-22—AAGP, Las Vegas.
Sept. 15-20—Int. Cong. on Alcohol & Alcoholism, Washington.
Sept. 24-26—Ky. Medical, Louisville.

Oct. 7-11—Pa. Medical, Pittsburgh.
Oct. 13-16—Va. Medical, Roanoke.
Oct. 14-18—ACS, Atlantic City.
Oct. 19-24—Am. Acad. of Ped., Chicago.
Oct. 27-Nov. 1—Am. Col. of Oph. & Otol., Chicago.

Nov. 11-15—Am. Col. of Prev. Med., New York.
Nov. 11-15—Am. Public Health Assn., New York.
Nov. 18-21—Southern Medical, New Orleans.

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All the Robitussins contain glyceryl guaiacolate, the outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs
ROBITUSSIN® A-C
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Pheniramine maleate . . . . . 7.5 mg.
Codeine phosphate . . . . . 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Dextromethorphan hydrobromide . 15.0 mg.
Alcohol, 1.4%

New! Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Phenylephrine hydrochloride . . . 10.0 mg.
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

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A·H·ROBINS

WVU Medical Center
—News—

• **Compiled from material furnished by the Medical Center News and Information Services, Morgantown, West Virginia.**

Dr. James G. Harlow, President of WVU, has announced the following appointments to the School of Medicine faculty:

Dr. Marcus M. Key, to be Associate Professor of Public Health and Preventive Medicine.

Dr. Kamal M. Benham, to be Instructor in Obstetrics and Gynecology.

Dr. George P. Tryfiates, to be Assistant Professor of Biochemistry.

Dr. Sue Karickhoff Core, to be Instructor in Biochemistry.

Doctor Key, an officer of the U. S. Public Health Service, is also serving as Acting Chief of the Appalachian Laboratory for Occupational Respiratory Diseases at the Medical Center. A native of Florida, he received his M. D. degree in 1952 from the College of Physicians and Surgeons of Columbia University. He is a member of the American Academy of Dermatology.

Doctor Benham received his medical degree from the University of Cairo. He served a three-year residency at University of Maryland Hospital, ending in 1963.

Doctor Tryfiates was born in Greece and holds degrees from the University of Toledo, Bowling Green State University, and Rutgers University. Before his appointment to the WVU faculty, he was instructor in pharmacology at the Duke University Medical Center.

Doctor Core is a native of Keyser and received her B. S. degree from WVU in 1961. She received her Ph. D. degree last May. From November, 1966, until just before her faculty appointment, Doctor Core was a research biochemist with the Armed Forces Institute of Pathology.

Scholarship Awarded

Fred A. Brindle of Martinsburg, a fourth-year medical student, has been awarded a $1,000 scholarship by Pfizer Laboratories.

The Company makes available such scholarships each year at each of the nation's medical schools.

Mr. Brindle received his pre-medical education at West Virginia University and is married. He was selected for the scholarship by school authorities on the basis of academic qualifications.

Ronald Wilkinson of Charleston (in white jacket), President of Alpha Omega Alpha at West Virginia University School of Medicine, welcomes new members into the medical fraternity. New members are (left to right): Albert Dow of Clairton, Pennsylvania; David King of Charleston; Timothy Bowers of Martinsburg; John Merrifield of Charleston; Johnsey Leef of Richwood; and Byron Kallam of Charleston. Frederick Newton of Hinton is also a new member of the Society. All are seniors in the School of Medicine and rank in the top 25 per cent of their class.

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The Month in Washington

• From the Washington Office of the American Medical Association.

A group of advisors to the Public Health Service and an AMA official separately emphasized the seriousness of the health manpower problem. The Allied Health Professions Education Subcommittee of the National Advisory Health Council said in a report to the PHS Surgeon General, Dr. William H. Stewart, that health manpower is the critical factor in the provision of health services in this nation.

"With the rising capacity of medicine to provide a satisfying array of services, the lowering of financial barriers to service, and the growing acceptance of a public responsibility to assure that all people have adequate medical service, needs and demands for medical care continue to outstrip their availability," the report said.

"Many people are struggling with approaches to the measurement of health manpower shortages. But no one figure can express the total need. And even if it were possible to envision ideal health services staffing for a community, a state, or a nation, the continuing development of new knowledge and techniques, new patterns of service, and new methods of payment are constantly changing the needs, both for numbers and varieties of health workers."

Urgent Need for Health Personnel

Dr. Alvin J. Ingram of Memphis, Tennessee, a member of the AMA Board of Trustees, told the AMA Conference on Aging and Long-term Care in Baltimore, that there is an urgent need for all categories of health personnel.

"We have been challenged by government to revamp our system of health care, to make it available to every one and to do so more economically than at present," Doctor Ingram said. "To do this will require not only larger numbers of health personnel, but more coordinated and efficient use of all members of the health team.

"The basic purpose of all medicine—research, education and practice—is the application of the art and science of the profession to the individual patient or to the community as a whole.

"Furthermore, we are constantly exposed to remarks about the brain drain, the siphoning of physicians trained in other countries and their acceptance here to fill our own voids, even at the expense of intensifying already desperate shortages in other nations.

"Yet we have our brain drain in this country—the consistent and progressive decrease in the ranks of practicing physicians as members of the profession turn from the primary responsibility of patient care to research, teaching and administrative service. In the past 15 years, the number of physicians in full time private practice has decreased at the rate of almost one per cent a year, from 75 per cent in 1950 to 62 per cent in 1965."

Doctor Ingram decried the growing dependence of the nation's health care system on foreign physicians.

"This dilemma can hardly be exaggerated," Doctor Ingram said. "Not one foreign graduate meets our domestic requirements which include graduation from an approved medical school which has undergone regular, competent inspection."

Doctor Ingram cited government figures showing that the percentage of foreign physicians in the United States had risen from 16 per cent in 1956 to 26 per cent in 1966 and that nearly half of them were from underdeveloped or developing countries that badly need their services at home.

PHS and NIH Criticized

The House Committee on Government Operations his issued its third report charging costly and inefficient administration of research grant programs by the National Institutes of Health and other Public Health Service bureaus.

The Congressional watchdog panel said the PHS had made relatively little effort to improve its administration of grants since the Committee's two previous reports in 1961 and 1962.

"Inadequate administrative performance is demonstrated, for example, by the inept handling of payments for the indirect research costs of grantees and the extremely poor administration of the General Research Support and Health Sciences Advancement Award programs," the recent report said.

"NIH and and other PHS bureaus were found to have made excessive indirect cost payments to grantees" (about $500,00 in one case).

AMA Supports Aid for Retardation Program

The American Medical Association supported legislation to continue federal aid for construction, training and research under the Health, Education and Welfare Department's retardation program, but opposes grants to help pay for initial staffing.

The AMA position was outlined by Dr. F. J. L. Blasingame, AMA Executive Vice President, in a letter to the House Public Health and Welfare Subcommittee.

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Professional Building, Wise, Va.
Pierce D. Nelson, M. D.

Obituaries

HERBERT MATHER BEDDOW, M. D.

Dr. Herbert M. Beddow, 67, of Charleston, died in a Charleston hospital on November 11 after a prolonged illness with leukemia.

A native of Cameron, Doctor Beddow received A. B. and B. S. degrees from West Virginia University and West Virginia Wesleyan College. In the 1920s, he was a teacher at Victory High School in Clarksburg for one year, and later was principal of Berkeley Springs High School for seven years.

It was after this career as a teacher that Doctor Beddow turned to medicine, and he received his M. D. degree from the Medical College of Virginia in Richmond in 1935.

Doctor Beddow never lost his interest in education. He was a member of the Kanawha County Board of Education for 18 years until his failing health forced his retirement in 1966. He was twice President of the School Board.

He served as volunteer physician for athletic teams of Stonewall Jackson High School in Charleston and rarely missed a game.

A specialist in obstetrics, Doctor Beddow was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association. He was a part owner of Staats Hospital in Charleston.

Survivors include the widow, Mrs. Katharine Staats Beddow; a son, James of Charleston; daughters, Mrs. Caroline Van Eaton of Cincinnati, Mrs. Katharine Antommaria of Pittsburgh; a sister, Miss Gladys Beddow of Charleston; and a brother, Dr. G. R. Beddow of Charleston.

WILLIAM GIBSON CLARK HILL, M. D.

Dr. William G. C. Hill, 88, of Moundsville, died in a hospital October 25 after a prolonged illness.

A native of Sistersville, Doctor Hill graduated from the Scio College of Pharmacy in 1902 and operated a drug store in Cameron until 1905. He then enrolled in the College of Physicians and Surgeons in Baltimore, where he received his M. D. degree in 1909.

He practiced in Cameron until his appointment as Marshall County Health Officer, a position he held for many years. He retired in 1953.

Doctor Hill had done postgraduate work at Johns Hopkins and Harvard Medical School.

He was an honorary member of the Marshall County Medical Society, the West Virginia State Medical Association and the American Medical Association.

The widow, Mrs. Lucille T. Hill, and several nieces and nephews survive.

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County Societies

CABELL

Dr. John Otto of Huntington has been elected President of the Cabell County Medical Society for the coming year. He will succeed Dr. William L. Neal, also of Huntington.

Other new officers chosen at the Society's regular monthly meeting at the Uptowner Inn in Huntington on October 12 include: Dr. David Haught, President Elect; Dr. Harold Kagan, Vice President; Dr. Winfield John, Secretary; and Dr. Jack Sheppe, Treasurer.

The Society admitted the following physicians to active membership: Drs. R. Lawrence Dunworth; Loren Carter Prince; Charles Joseph Anton, Jr.; Charles K. McKown; Floyd Deen, Jr.; and Gaston Periera DeLemos.

The following physicians were admitted to associate membership: Drs. James Elwood Eshenaur; Donald M. Mandelbaum; Domingo Abella; Jose I. Ricard; Perla P. Kelz; and Siegfried Kelz.—Harold N. Kagan, M. D., Secretary.

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FAYETTE

Dr. Thomas C. Sims of Longacre was elected President of the Fayette County Medical Society for 1968 during the Society's regular monthly meeting, which was held on November 1 at Hawks Nest Country Club.

He succeeds Dr. Richard M. German, Jr., of Oak Hill.

Other new officers for next year include:

Dr. C. H. Lee of Montgomery, Vice President; Dr. A. R. Bautista of Montgomery, Secretary-Treasurer; and Drs. Joe N. Jarrett of Oak Hill and T. Kerr Laird of Montgomery, Delegates to the West Virginia State Medical Association.—Joe N. Jarrett, M.D., Secretary.

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McDOWELL

The regular monthly meeting of the McDowell County Medical Society was held at Stevens Clinic Hospital in Welch on October 11.

Dr. Ray Burger was elected Treasurer of the Society for the remainder of 1967.

Dr. Mario Cardona was elected to membership in the Society.—Joseph C. Ray, M. D., Secretary.

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MERCER

The Mercer County Medical Society and the Mercer County Bar Association held a joint meeting at the West Virginian Hotel in Bluefield on October 16.

Guest speaker was Col. Frederick Bernays, a Washington attorney. He gave an interesting talk on "Cause of Riots and Racial Strife in the United States." He expressed the opinion that riots are fostered by the

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Dr. J. Elliott Blaydes, the President, appointed Drs. M. B. Smith, William Bruch and David Wayne to a Family Hygiene Committee to work on the problem of hygiene education in the schools.—John J. Mahood, M. D., Secretary.

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MONONGALIA

Dr. H. Oliver Williamson of the Medical College of South Carolina was guest speaker at the regular monthly meeting of the Monongalia County Medical Society, which was held on October 3 in Morgantown.

Doctor Williamson presented an interesting talk on "Recent Advances of the Oral Contraceptives." The subject was well presented and was illustrated by slides.

Forty-two members and guests attended the meeting.—Robert Greco, M. D., Secretary.

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RALEIGH

The Raleigh County Medical Society held its regular monthly meeting jointly with the New River Dental Society and the New River Pharmaceutical Association at the Elks Club in Beckley on October 19.

Mr. Jim Brulatour, Managing Director of Dale Carnegie Courses in Charleston, was guest speaker. His topic was "The Third Leg Is Missing." He discussed in particular personal attitudes, personal skills and knowledge.

Fifty physicians, 15 dentists and 12 pharmacists attended the meeting.—Forest A. Cornwell, M. D., Secretary.

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TYGART'S VALLEY

The organizational meeting of the Tygart's Valley Medical Society, a consolidation of the Barbour-Randolph-Tucker and the Taylor County medical societies, was held at Mellie's Restaurant in Philippi on October 19.

Dr. Ernest E. Hutton, Jr., of Elkins, was elected President of the Society for 1968. Other new officers are: Dr. James M. Carhart of Philippi, First Vice President; Dr. Wallace B. Murphy of Grafton, Second Vice President; Dr. Vernon E. Duckwall of Elkins, Treasurer; and Dr. A. Kyle Bush of Philippi, Secretary.

Dr. Philip M. Sprinkle of Morgantown, Chairman of the Division of Otolaryngology at the West Virginia University Medical Center, presented the scientific program for the evening. In a paper entitled "Advances in Otology," Doctor Sprinkle classified the types of otitis media and uses of the various methods of treatment. He also discussed mastoid disease and the grafting of the tympanic membrane and vertigo as related to middle ear disease and other causes.

Twenty-three members and guests attended the meeting.—A. Kyle Bush, M. D., Secretary.

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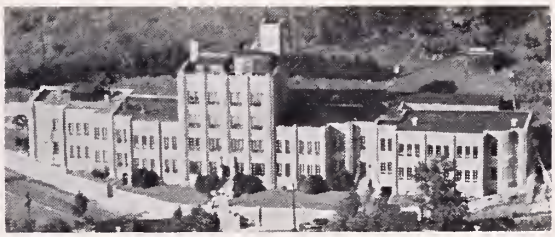

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24th ANNUAL CONFERENCE IN CHICAGO

The 24th Annual Conference of State Presidents, Presidents Elect, National Officers and Committee Chairmen of the Woman's Auxiliary to the American Medical Association was held in Chicago, October 8-11.

Among subjects discussed at the conference were mental health, Manpower crisis, sex education, home centered health care and international health.

Representing West Virginia were Mrs. Rupert W. Powell of Fairmont, President of the Woman's Auxiliary to the West Virginia State Medical Association, and Mrs. J. A. B. Holt, President Elect of the State Auxiliary.

The conference opened on October 8 with four regional dinners, with the Auxiliary's regional vice presidents presiding.

Mrs. Karl F. Ritter of Lima, Ohio, President of the Auxiliary, opened the October 9 session, and Dr. E. B. Howard delivered the keynote address. Mrs. Ritter then introduced Mrs. C. C. Long of Ozark, Arkansas, President Elect and presiding officer.

Speakers during the four-day session included the following: Dr. Roy Ritts, Director of Medical Research for the AMA; Dr. Dwight Wilbur, President Elect of the AMA; Dr. A. Rex Kirkley, Assistant Manager of the AMA Washington Office; Rep. Robert Michel of Illinois; Mrs. Hans Odegaard, a lecturer from Denmark; and Dr. Ernest B. Howard, Assistant Executive Vice President of the AMA.—Mrs. John A. B. Holt, President Elect.

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GREENBRIER VALLEY

Mr. Clair Boso, venereal disease investigator for the State Health Department, was guest speaker at a meeting of the Woman's Auxiliary to the Greenbrier Valley Medical Society, which was held on October 24 at the home of Dr. and Mrs. James Baker in White Sulphur Springs.

Mr. Boso's topic was "Venereal Disease—Increasing Health Threat."

During the business meeting members of the Auxiliary decided to publish a cookbook featuring favorite

recipes of doctors' wives from all over the State. It is hoped that the cookbook will be ready for sale late next summer.

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HARRISON

The regular monthly meeting of the Woman's Auxiliary to the Harrison County Medical Society was held on November 2 at the Stonewall Jackson Hotel in Clarksburg. Twenty-eight members and 18 guests attended.

Mrs. Hugh M. Brown, President, welcomed the members and guests and introduced Mrs. Charles S. Harrison, Health Careers Chairman, who served as chairman for the program, which consisted of the viewing of two films on venereal disease entitled "A Quarter-Million Teenagers" and "Dance, Little Children." The films were presented by Mr. Samuel B. Folio, public health disease investigator with the West Virginia State Health Department.

Mr. Folio discussed the increasing number of cases of venereal disease being reported on the national, state and county level. He stressed that the highest incidence occurs among teenagers, regardless of socio-economic background. At the conclusion of his commentary, Mr. Folio urged the county Auxiliary to adopt the project of informing the local teenagers regarding venereal disease through their respective school systems, by incorporating courses of instruction through established health classes.

A brief business meeting followed the program, with Mrs. Hugh M. Brown presiding.—Mrs. Robert D. Hess, Publicity Chairman.

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LOGAN

Mrs. Mark Spurlock of Logan entertained the Woman's Auxiliary to the Logan County Medical Society at her home on October 25.

Mrs. Harold Van Hoose of Man, the President, presided at the business session.

Eleven members attended the meeting.

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MERCER

A program on "Medicine and Religion" highlighted the October meeting of the Woman's Auxiliary to the Mercer County Medical Society, which was held at the Town 'n Country Restaurant in Princeton.

Mrs. C. D. Pruett moderated the panel discussion. Panelists included Dr. John Bryan and the Rev. Jerry Connor.

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MONONGALIA

The October meeting of the Woman's Auxiliary to the Monongalia County Medical Society was held at Lakeview Country Club.

The group voted to make contributions to the Colin Anderson Center for Retarded Children in St. Marys; Project HOPE; and AMA-ERF.

Mrs. Byron M. Bloor was Chairman of the Hostess Committee for the meeting.

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Book Reviews

THE OFFICE ASSISTANT IN MEDICAL PRACTICE—By Portia M. Frederick, Instructor in Medical Office Assisting, West Valley Junior College, Campbell, California, and Mary E. Kinn, C.P. S., Chairman of the Certifying Board, American Association of Medical Assistants. W. B. Saunders Company, Philadelphia, London. 1967. Pp. 461. Illustrated. Price: $7.50.

The "Office Assistant" is a 30-page book of general technical and medical information for the nurse, receptionist or technician. There are several appendages pertaining to reference books, abbreviations, symbols and diagnostic laboratory procedures. The index is adequate.

The authors are instructors in Medical Office Assisting, which is a new division of paramedicine, albeit an important one.

The purpose of the book is to provide general orientation in the whole field of assisting.

There is at the beginning, a sample day, or an average day in the activities of the office assistant. Certainly all of us would appreciate this type of assistant. It also advises the development of a written procedure manual for every office to explain all items of this particular office covering all activities.

All the little office details receive the full treatment. The chapters on telephone and appointments are especially recommended.

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PATHOLOGY—By Stanley L. Robbins, M. D., Professor and Chairman, Department of Pathology, Boston University School of Medicine. W. B. Saunders Company, Philadelphia, London. 1967. Pp. 1434; Illustrated. Price: $20.50.

In brief, this book consists of 1,434 pages divided into 32 chapters covering all the systems of the body. In depth it is a complete catalogue of pathology. This statement is made in deference rather than derision. This book is not the usual encyclopedia devoted to isolated facts and fancies with an idea as to totality without nourishment. Rather, the author presents his material in such a way that his stated purposes are mostly accomplished.

Doctor Robbins prefaces his book with "there continues to be a need for a presentation of pathology specifically designed and written for students and clinicians . . . such traditional morphology has been included as befits our current understanding of disease, without attempting to make pathologists of the readers . . . why and how . . . clinical correlation." To a practicing pathologist the book may appear as a compendium of his subject but the medical student and clinician would find this book a very valuable addition to his library.

In addition to the material presented, the author emphasizes pertinent points and ideas by use of dark lettering and script. This makes for easier reading and substance. The photographs are beautiful. If possible, they have been improved over previous editions. One of the most prominent aspects of this book is the correlation of the pathology to the clinical aspects of medicine. This feature could be a valuable legacy for the practicing pathologist. I am amazed at the completeness of the material—such as a rather nice discussion of Sheehan's postpartum necrosis, the various types of hepatitis, the diseases of immune origin, genetics and disease, etc.

In summary, I would thoroughly recommend this textbook of pathology to students, to clinicians, and, yes, even to pathologists since I do believe that all will be able to extract that material which is of consequence to their interests.—Herman Fischer, M. D.

★ ★ ★ ★

AMERICAN MEDICAL DIRECTORY—24th EDITION 1967—Published by the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610. Price: $60.

The 24th, 1967 edition of the *American Medical Directory* is a brief history of all physicians in the United States. The information is coded in such a manner that a considerable degree of information can be secured about any physician in a very short time. In addition to the registration by states, there is an alphabetical directory which enters name and address of all physicians.

The print is excellent and names are highlighted in capital letters. The *Directory* is a must for hospital groups and physicians with a large inter-professional correspondence. All doctors will find it a frequent, useful referral.

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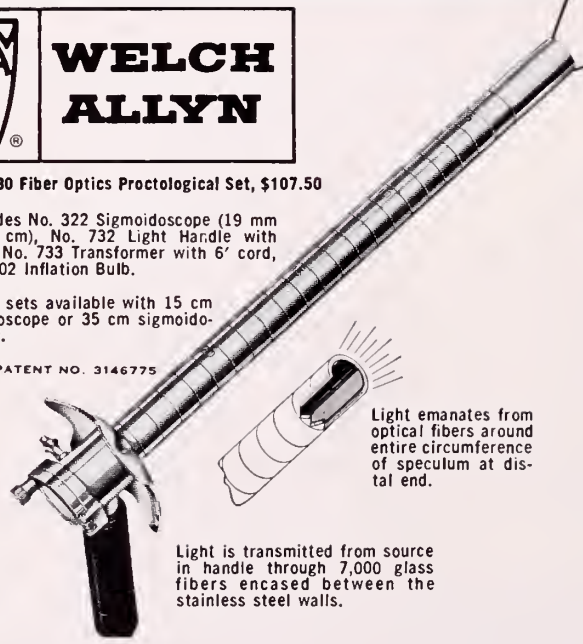

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WANTED—Elderly physician to live in small hospital in pleasant community. Minimum professional duties. Write OAR, The West Virginia Medical Journal, Box 1031. Charleston, W. Va. 25324.

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WANTED—Internist urgently needed in a growing northeastern West Virginia community; drawing area is approximately 23,000; modern hospital with excellent facilities; office space available; guaranteed annual income; centrally located for vast recreational facilities. Write RLH, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

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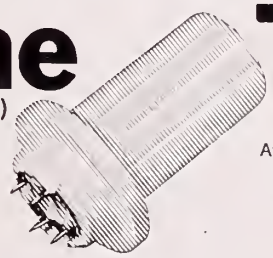

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Warn against hazardous occupations requiring complete mental alertness. Use caution in administering to addiction-prone patients or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In elderly and debilitated and in children over five, limit dosage to smallest effective amount, increasing gradually as needed and tolerated. In general, concomitant use with other psychotropics is not recommended. Paradoxical reactions have been reported in psychiatric patients and hyperactive aggressive children. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Observe usual precautions in presence of impaired renal or hepatic function, impending depression and suicidal tendencies.

Adverse reactions: Drowsiness, ataxia and confusion may occur, especially in elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. Syncope occurs rarely. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis, jaundice and hepatic dysfunction) may develop occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy. Individual maintenance dosages should be determined.

Dosage: Oral—Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d.

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Vol. 63 No. 12

Medical Journal

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Tears without grief

Crying Spells–psychic tension with depressive symptoms?
"I don't know what's the matter with me lately...I cry and I cry... and I really don't know why I do."

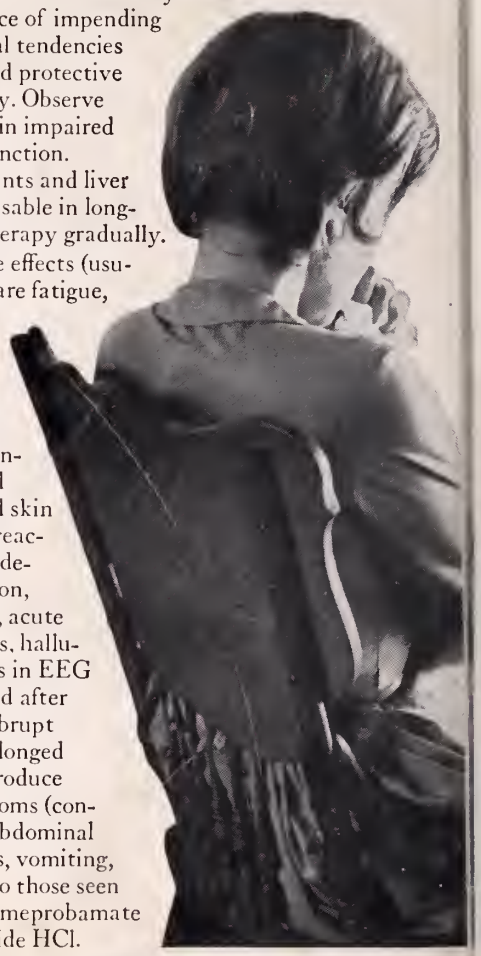
A woman often is not conscious of the real reasons for her crying spells or refuses to admit them to herself. On probing, you may find that frequent weeping, like insomnia or neurotic fatigue, often is an expression of psychic tension. She needs sympathy and reassurance, and perhaps a calming agent to help her over her crisis. Consider prescribing Valium (diazepam) for her. It usually reestablishes calmness promptly. Crying spells and other secondary depressive symptoms normally subside as the tension is relieved. Your patient then can cope more easily with stresses to which she is subjected. Valium (diazepam) is generally well tolerated, and on proper maintenance dosage usually does not impair mental acuity or ability to function. If side effects such as ataxia and drowsiness occur, they usually disappear with dosage adjustment.

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Infants, patients with history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, unt correct maintenance dosage is established, advise patient against possibly hazardous procedures requiring complete mer tal alertness or physical coordination. Driving during therap not recommended. In general, concurrent use with other psych tropic agents is not recommended. If such combination therap is used, carefully consider individual pharmacologic effects- particularly with known compounds which may potentiate ac tion of Valium (diazepam), such as phenothiazines, barbiturate MAO inhibitors and other antidepressants. Advise patient against simultaneous ingestion of alcohol or other CNS depre sants. Safe use in pregnancy not established. Employ usu precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.



Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage: *Adults:* Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions.)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.

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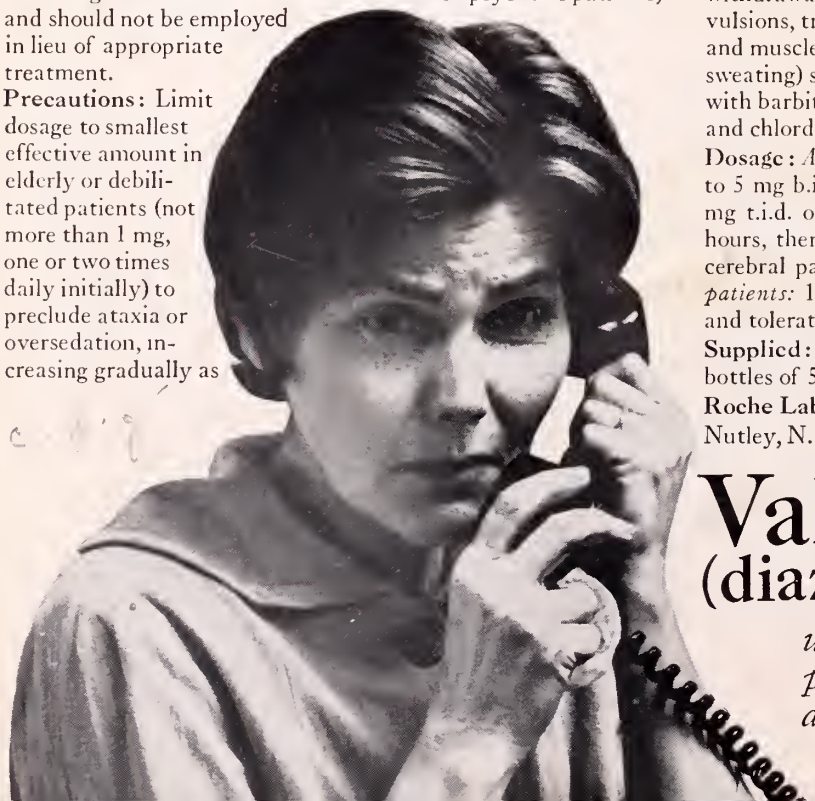

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